Heritage Lifecare Limited - Ellerslie Gardens Home and Hospital

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Ellerslie Gardens Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 April 2018 End date: 12 April 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 77

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Ellerslie Gardens Home and Hospital provides rest home and hospital level care for up to 97 residents. The service is operated by Heritage Lifecare Limited and managed by a facility manager and a clinical services manager. Residents and family/whanau spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service`s contract with the district health board. The audit process included review of policies and procedures, review of residents` and staff records, observations and interviews with residents, family members, managers, staff and a general practitioner.

There were no areas requiring improvement. The one corrective action required from the previous audit has been effectively addressed.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to interpreting services if required.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Business quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies any trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risk, including health and safety risk are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision, evaluation, review and exit are provided within time frames that safely meet the needs of the residents and contractual requirements.

All residents have interRAI assessments completed and individualised care plans are current and up to date. When there are changes to the resident's needs a short-term plan is developed and integrated into a long-term plan, as needed. All care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

There is current building warrant of fitness which is displayed at reception.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support minimisation of restraint. Three enablers and three restraints were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	0	0	0
Criteria	0	40	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints/compliments policy and associated forms meet the requirements of Right 10. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The complaints/compliments register was reviewed. The register showed 17 complaints had been received for 2017 and three for the first quarter for 2018. All complaints had been actioned through to an agreed resolution and were completed within the required timeframes. Action plans showed any required follow-up and improvements have been made where possible. Each complaint was signed off by the facility manager and dated. The facility manager is responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. One coroner`s case from August 2017 is still in progress.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	Residents and family members stated they were kept well informed about any changes to their relative`s health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents` records reviewed. Staff understood the principles of open disclosure which is supported by policies that meet the requirements of the Code. Staff know how to access interpreter services although reported this was rarely required due to staff being able to

provide an environment conducive to effective communication.		provide interpretation as and when required and the use of family members if needed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The organisation has developed a business plan inclusive of the purpose, scope, values, direction and objectives set for the organisation with operational considerations included. In addition, the facility manager has personalised the objectives specific to this service for 2018 – 2019. A sample of weekly and monthly reports to the support office/management showed the information required was reported as requested and was followed up by the national quality manager and quality team. The service is managed by a facility manager who holds relevant management qualifications and is a registered nurse. The facility manager has been in this role for five years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency by attending related business courses and the organisation`s annual conference for facility managers which was attended in November 2017. The service holds contracts with the Auckland DHB for up to 96 residents. Rest home care (42) includes two under 65 years (YPD) who are rest home care level, hospital (33), boarder (one) and respite care (one in hospital).
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement and is understood by staff. This includes the management of incidents and complaints, audit activities, a regular satisfaction survey, monitoring of outcomes, clinical incidents, including infections, and restraint minimisation and safe practice. Terms of reference and meeting minutes reviewed confirmed more than adequate reporting systems and discussion on quality matters. Regular review and analysis of key quality indicators occurs, and related information is reported and discussed at the quality/staff meetings. Minutes of meetings reviewed includes discussion on pressure injuries, restraints/enablers, falls, complaints, incident/events, infections, audit results and activities. Staff reported their involvement in quality and risk management through the internal audit activities that they are involved in where possible. The clinical services manager has only been in this role for two weeks but will be orientated to collate all data and report to the facility manager who then reports all information and outcomes onto the organisation`s support office monthly and as required. Any relevant corrective actions are developed and implemented to address any shortfall and demonstrated a continuous process of quality improvement is occurring. Resident and family surveys are completed in June annually. The outcome of the 2017 survey provided positive comments for all staffing and management matters.

		Heritage Lifecare Limited (HLL) has reviewed the policies and procedures since the previous audit. Any new and/or draft policies requiring consultation are sent out to the facilities for staff to make any changes or have input if needed. The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The facility manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported on the electronic incident management system now implemented (GOSH) and management can access this information anytime. The facility manager described essential notification reporting requirements including pressure injuries. The facility manager advised there has been one coroner`s case that has been in progress since August 2017. All appropriate information is filed, accessible and stored securely in the interim time awaiting final closure of this case.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources management policies and procedures are based on good employment practice and relevant legislation. The recruitment process includes reference checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation`s policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review annually. Education is planned on an annual basis including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider`s agreement with the ADHB. The facility manager is responsible for the provision of education and will be assisted by the newly appointed clinical services manager. ‘Toolbox talks’ are conducted during the handover between shifts and staff interviewed enjoyed these sessions and updates. There are five registered nurses who are fully competent to undertake interRAI assessments and three registered nurses are currently in training. The facility manager has management access regarding interRAI and the new clinical nurse manager is interRAI trained however needs to up-date the AIS exams. Records reviewed

		demonstrated completion of the required training and completion of annual competencies.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The policy states that staffing levels reflect the number of residents, acuity of residents, residents` care levels, and the layout of the facility. The facility manager and the clinical services manager adjust staffing levels to meet the changing needs of residents. An afterhours on call roster is in place with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family/whanau interviewed supported this. Observations and review of rosters confirmed adequate staff cover has been provided with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 registered nurse coverage.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. There was one resident identified on the medication electronic device who was overdue for a medication review; however, evidence was sighted in the resident’s file to show that the GP and medication review had occurred. There were five residents who were self-administering medications at the time of audit. Appropriate processes

		were in place to ensure this is managed in a safe manner; however, one resident did not have their medication stored securely in their bedroom. Evidence was provided by the end of the audit that the resident's medication was now stored in a locked draw. There is an implemented process for comprehensive analysis of any medication errors. In August 2017, as a result of a medication error, a section 31 notification was required, the case was referred to a coroner. At the time of the audit the case remained open.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by one of three cooks, supported by kitchen staff, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The facility was issued with a food safety guide certificate on the 22 December 2017. A grade is pending as the facility is currently awaiting an inspection from the Council. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. All food is cooked on site and delivered to two dining rooms with residents provided with the option of eating in their rooms. Evidence of resident satisfaction with meals was verified by resident and family interviews and in residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of five interRAI trained registered nurse. A further three registered nurses are in the process of completing their interRAI training, the facility manager has access to interRAI and the new clinical services manager is also interRAI trained, however needs to update her yearly competency exam. Residents and families confirmed their involvement in the assessment process. The previous audit identified an area for improvement to ensure that all interRAI assessments were conducted in the required timeframes and that pressure injury assessments were consistent using best practice guidelines.

		The corrective action is now addressed, and records were available to demonstrate actions/processes taken for identified pressure injury's and wounds such as referrals to wound clinical nurse specialist, GP reviews, dietician and physio and that staff have also attending training.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident. The 'house doctor' interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a very good standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities programme is provided by two activities co-ordinators of one whom is training to become a diversional therapist. The activities staff support residents from Monday to Saturday 8.30am to 3.30pm. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six- monthly care plan review. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Several residents are independent and encouraged to connect and interact with the community while other residents are supported by the staff and groups in the community to partake in regular community activities and groups. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and day to day discussions. Residents interviewed confirmed they find the programme interactive and fun
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care and there is evidence of working documents throughout the five residents' files reviewed. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, skin tears, falls and challenging behaviours. When necessary, and for

		unresolved problems, long term care plans are added to and updated. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness dated expiry 10 March 2019 was sighted framed and displayed in the reception to the facility.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the respiratory tract, urinary, wound, gastroenteritis and conjunctivitis infections. The infection prevention and control (IPC) coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the facility and clinical manager/quality, IPC committee and organisation. Data is benchmarked externally within the group. The facility in November of 2017 had 15 residents diagnosed with a respiratory tract infection. The residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of ongoing infection. Care staff interviewed demonstrated knowledge of residents who also have a higher risk of infections and the preventative interventions required. The respiratory tract infections were resolved and there were no new residents diagnosed for the month of December 2017.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound knowledge of the organisation's policies, procedures and practice and the role and responsibilities. On the day of the audit three residents were using restraints and three residents were using enablers, which were the least restrictive and used voluntarily at their request. Restraint is used as a last resort when all alternatives have been explored. This was

		evident on review of the restraint approval group minutes, files reviewed and from interview with staff.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.