

# St John's Parish (Roslyn) Friends of the Aged and Needy Society - Leslie Grove Home

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## Introduction

This report records the results of a Certification 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 Health and Disability Auditing New Zealand 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:

<b>Legal entity:</b>	St John's Parish (Roslyn) Friends of the Aged and Needy Society
<b>Premises audited:</b>	Leslie Grove Home
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 13 July 2018    End date: 13 July 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	30



# Executive summary of the audit

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## 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
Yellow	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
Red	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

Leslie Groves home is operated by the St John's Parish (Roslyn) Friends of the Aged and Needy Society and cares for up to 34 residents requiring rest home level care. On the day of the audit there were 30 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff and the general practitioner.

The residents, relatives and general practitioner spoke highly of the care and service provided at Leslie Groves Home. The service has a well-established quality system that identifies ongoing quality improvement.

Leslie Groves Rest Home is managed by an experienced clinical nurse manager who has worked at the service for over three years. The clinical nurse manager reports to the chief executive (RN) at the sister facility. The chief executive visits at least two days a week and reports monthly to the board (or more frequently if required).

The service has exceeded the standard around good practice in relation to falls reduction.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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The staff at Leslie Groves ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is discussed with residents (where able) and relatives and documented. Staff interviewed were familiar with processes to ensure informed consent. Complaints and concerns have been managed and a complaints register is maintained.

## 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.
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Quality management processes are reflected in the businesses plan's, goals, objectives and policies. Corrective actions are identified and implemented. There is a current operations plan in place. A risk management programme is in place, which includes incident and accident reporting and health and safety processes. Staff document incidents and accidents. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The service has an annual training schedule for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## 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.
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There is information available for residents and relatives prior to entry to the service. Residents are assessed prior to entry to the service. Care plans are individually developed with the resident, and family/whānau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Activities are provided that are meaningful and ensure that the resident maintains involvement in the community. Medication management policies and procedures meet current guidelines. All staff who administer medications have completed annual competencies for medication administration. There are three monthly GP medication reviews. Food services are contracted to a food service company who work from the Leslie Groves hospital site kitchen and transport meals to the rest home. The menu is designed by a dietitian with summer and winter menus. Dietary requirements are provided where special needs are required.

## 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.
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Leslie Grove Rest Home has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Medical equipment and electrical appliances have been calibrated. There is a designated laundry at the hospital site which includes the safe storage of cleaning and laundry chemicals. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas that include lounge and dining areas, and

smaller seating areas. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade provided.

## 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.
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There is a restraint policy that includes the provision of a non-restraint environment. All staff receive training on restraint minimisation and management of behaviours that challenge. There were no residents using enablers and no residents using restraint.

## 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.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The quality manager is also the infection control coordinator. The infection control coordinator has attended external education and coordinates education and training for staff. There is a suite of infection control policies and guidelines to

support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility.

## 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)
<b>Standards</b>	1	44	0	0	0	0	0
<b>Criteria</b>	1	92	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	Discussions with staff (three caregivers, one registered nurse both from the hospital unit, one clinical nurse manager (CNM), the chief executive and the quality manager) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Eight residents and two relatives were interviewed and confirmed the services being provided are in line with the Code.
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	There are established informed consent policies/procedures and advanced directives. General consents are obtained on admission. Specific consents are obtained for specific procedures such as influenza vaccine. Two family and eight residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. Resuscitation status had been signed by the residents.  Six resident files reviewed had signed admission agreements.

consent.		
Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Client right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service entrance area. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members interviewed were aware of their access to advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the care plans in files sampled. Residents and relatives interviewed verified that they have been supported and encouraged to remain involved in the community. Church groups, schools and entertainers have been invited to visit the rest home.
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. There were no complaints received in 2017 and one in 2018 to date. This complaint was reviewed and showed appropriate acknowledgement, investigation and resolution within required timeframes. Processes are in place to ensure that any complaint received is managed and resolved appropriately. Residents and family members interviewed advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights.	FA	The Code and advocacy pamphlets are located at the main entrance of the service. On admission, the CNM discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code.
Standard 1.1.3:	FA	Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records,

<p>Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>resident's privacy and dignity. A confidentiality agreement is signed by staff at commencement of employment. Church services are held weekly, and resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is a prevention of abuse and neglect policy and staff education and training on abuse and neglect has been provided.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. There are no current residents who identify as NZ Māori living at the facility. The service has a Māori health plan and a cultural safety policy, which includes cultural safety and awareness. The service has established links with local Māori and staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. There is multi-cultural staff employed at Leslie Groves rest home and the activities programme celebrates other cultures and special cultural celebrations. Caregivers interviewed could describe learning about their residents and cultures.</p> <p>Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged.</p>
<p>Standard 1.1.7: Discrimination</p>	FA	<p>A staff code of conduct is discussed during the new employee's induction to the service. Code of conduct training is also provided through the in-service training programme. Policy and procedures related to discrimination ensure residents receive services free from any discrimination, and that residents are not</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>subjected to any form of coercion, harassment, sexual or other exploitation. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. Interviews with caregivers and the registered nurse confirmed their understanding of professional boundaries, including the boundaries within their roles and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>The service meets the individualised needs of residents with needs relating to rest home level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-service training. The quality manager and clinical nurse manager is responsible for coordinating the internal audit programme. Monthly quality meetings, staff unit meetings, clinical meetings and regular residents' meetings are conducted. There is a regular in-service education and training programme for staff. Staff interviewed stated that they feel supported by the registered nurse and management team.</p> <p>Evidence-based practice is evident, promoting and encouraging good practice. A rotating on call roster is shared between the chief executive, quality manager and clinical nurse managers. A house general practitioner (GP) visits the facility weekly and a nurse practitioner is available on request for mental health support. The service receives support from the local district health board (DHB). A podiatrist is on-site every six-weeks. The service has links with the local community and encourages residents to remain independent. Residents and relatives interviewed spoke positively about the care and support provided.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Management interviewed described an open-door policy.</p> <p>Evidence of communication with family/whānau is documented and held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. A sample of ten accident/incident forms reviewed from June and July 2018, identified that family are kept informed. Relatives interviewed stated that they are kept well-informed when their family member's health status changes. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur monthly.</p> <p>The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident</p>

		should they wish to do so.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Leslie Groves is owned and operated by the St John's Parish (Roslyn) Friends of the Aged and Needy Society. The board meets monthly and provides a governance role. The service provides care for up to 34 residents at rest home level care. On the day of the audit, there were 30 residents. All residents were under the ARCC contract.</p> <p>Leslie Groves Rest Home is managed by an experienced clinical nurse manager who has worked at the service for over three years. The clinical nurse manager reports to the chief executive (RN) at the sister facility. The chief executive visits at least two days a week and reports monthly to the board (or more frequently if required). A quality manager (registered nurse) based at the sister facility supports the clinical nurse manager with weekly visits and assists with quality reporting and benchmarking. The 2018 strategic plan and operation/quality plan are being implemented. Quality goals include specific goals to reduce the falls rate.</p> <p>The clinical nurse manager has completed at least eight hours of training related to management of a rest home in the past year</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The quality manager and Leslie Grove hospital CNMs provide cover during a temporary absence of the rest home clinical manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	FA	<p>A quality and risk management programme is in place. The quality manual and the strategic, business/quality and risk management plans and procedure describe Leslie Grove's quality improvement processes. Quality goals were documented in the operations quality plan and the quality meeting minutes.</p> <p>The service has comprehensive policies/procedures to support service delivery. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Staff are made aware of any policy changes through staff meetings, evidenced in meeting minutes. The monthly collating of</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>quality and risk data includes monitoring accidents and incidents, infection rates, restraint use and results of annual resident and family satisfaction surveys. Internal audits regularly monitor compliance. There are rest home resident meetings held monthly with a good attendance rate. The CNM's from the rest home and sister facility meet the QM and CE fortnightly ensuring all management staff are aware of all areas.</p> <p>An annual resident and relative satisfaction survey is completed. The 2017 results demonstrated a 60% return rate with overall positive outcomes. Corrective actions were established in the lower ranking areas.</p> <p>A corrective action form is completed where areas are identified for improvement and included evidence of implementation and sign off. Quality data is analysed for trends and is discussed at staff and management meetings, at the monthly board meeting, at handovers and displayed in the staff room.</p> <p>The quality programme is linked to the annual training plan with extra and impromptu training offered as issues are identified. A quality improvement register is maintained and lists the key objectives, interventions and evaluations of the improvements listed. A health and safety programme is in place, with documented objectives for 2018 and regular reviews. There is an implemented risk register, which includes managing identified hazards. Health and safety meetings are conducted each month.</p> <p>Strategies are implemented to reduce the number of falls. This includes, (but is not limited to), individual resident reviews and staff education. Residents at risk of falling have a falls risk assessment completed with strategies implemented to reduce the number of falls. Care staff interviewed confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	<p>FA</p>	<p>The service collects all incident and accident information reported by staff on a paper-based system. Incident and accident data is collected and analysed monthly and a report documented for the monthly quality and staff meetings. Ten resident related incident forms were reviewed for June and July 2018. Each event involving a resident reflected a clinical assessment and follow-up by a RN and included opportunities to minimise the risk of further incidents. Care staff interviewed were very knowledgeable regarding the care needs for all residents. Discussions with the clinical nurse manager, chief executive, and quality manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. One norovirus outbreak July 2017 was notified to Public health.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	<p>FA</p>	<p>The recruitment and staff selection process require that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files (one clinical nurse manager, one registered nurse, one activities coordinator and two caregivers) were reviewed, and</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 20 years.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals have been conducted for all staff whose files were sampled.</p> <p>A completed in-service calendar for 2017 exceeded eight hours annually. The management team and registered nurses attend external training including seminars and education sessions with the local DHB. The CNM and RN have completed their interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. In addition to the clinical nurse manager who works full-time, the rest home has a full time registered nurse working Monday to Friday and the quality manager based at the sister facility provides regular support. The on-call roster is shared between the CE, QM, the rest home CNM and CNM's from the affiliated hospital facility. Cleaning staff are employed over seven days a week. An activities coordinator is rostered Monday to Friday. Staff reported that staffing levels and the skill mix were appropriate and safe. Residents interviewed advised that they felt there is sufficient staffing.</p> <p>Leslie Groves rest home hospital operates as one unit</p> <p>The rest home currently has 30 residents. The morning shift is covered by one RN and three caregivers (all working full shifts). On the afternoon shift there are three caregivers (two full and one four-hour shift) and on night shift there are two caregivers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' station. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. Medication charts are stored electronically.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment was completed on admission in files sampled. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Code of rights, advocacy, informed consent, and palliative policy and the complaints procedure. The admission agreement reviewed aligns with the ARC contract and exclusions from the service are included in the admission agreement. All six resident files reviewed had signed admission agreements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The transfer/discharge/exit procedures include a transfer/discharge form and the completed form is placed on file. The registered nurse stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident. There is evidence of regular liaison with the DHB to ensure a smooth transition.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The service has implemented an electronic medication management system. There are policies in place for safe medicine management that meet legislative requirements. Medications were all safely stored. All 12 medication charts sampled met legislative prescribing requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. The medication trolley is kept locked in the nursing station, which is also locked when not in use. All eye drops in use had been dated on opening and none were expired. Staff were observed during the lunchtime round, to be safely administering medications. The registered nurse and care staff interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. There was one resident self-medicating on the day of audit; this resident had a signed competency on file which is reviewed on a three-monthly basis. The use of 'as required' (PRN) medications are monitored and electronically signed with times when administered. Medication charts sampled had photo identification and allergies/adverse reactions documented. The medication charts sampled identified that the GP had seen the resident three monthly and the medication chart was electronically signed. The RNs carry out weekly checks on emergency equipment. Oxygen cylinders are kept in a locked cupboard. Sharps are disposed of into approved biohazard containers.</p> <p>The medication fridge temperatures are recorded regularly, and these were within acceptable ranges.</p>



<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>A food control plan is in place. There is an external contractor providing the food services for both Leslie Groves sites. The contracted company uses a commercial kitchen at the hospital site. A dietary assessment is completed by the RN as part of the assessment process and this includes likes and dislikes. There was evidence of residents receiving supplements. Fridge and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridge and freezers was covered and dated. The external contractor conducts audits as part of their food safety programme. Special or modified diets are catered for. Soft and puree dietary needs are documented in files sampled. This includes consideration of any particular dietary needs (including cultural needs).</p> <p>Food is transported to the rest home via hot boxes. Staff record the temperature of hot and cold dishes prior to serving. Resident and families interviewed were complimentary of the food service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The reason for declining service entry to potential residents to the service would be recorded on the declined entry form, and when this has occurred, the clinical nurse manager stated it had communicated to the potential resident/family/whānau and the appropriate referrer.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Initial assessments are completed within expected timeframes, information is gathered from a variety of sources such as family, discharge letters, and needs assessor assessments. The facility has embedded the interRAI assessment protocols within its current documentation. The RN and CNM are competent in the use of interRAI. All residents have interRAI assessments completed. InterRAI initial assessments and assessment summaries were evident in printed format in the files reviewed. Files reviewed identified that risk assessments had been completed on admission and had been updated at the time of the care plan review.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused,</p>	FA	<p>The long-term care plan recorded the resident's problem/need, objectives and interventions for identified issues in all six files reviewed. Short-term care plans were utilised for acute health needs in files sampled. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident.</p>

integrated, and promote continuity of service delivery.		
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Care plans reviewed were current with interventions updated. Contenance products are available and resident files include a urinary continence assessment. Specialist continence advice is available as needed and this could be described.</p> <p>Monthly weighs have been completed in all files sampled. Referral to dietitian occurs as required, as confirmed by registered nurses interviewed.</p> <p>Dressing supplies are available, and all treatment rooms are stocked for use. There were three residents with wounds at the time of audit (one chronic venous ulcer, one surgical wound and lesions on the lower leg). All wounds had wound management plans in place. There were no pressure injuries on the day of the audit. Specialist wound care nurse and district nursing is available on request. Monitoring forms include (but are not limited to); pain, weight and vital signs, food and fluid and behaviour monitoring (where required).</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	FA	<p>The activities coordinator has worked at the service for many years and works 28 hours on week one then 23.75 hours on week two. Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. On the day of audit, residents were observed playing a card game. The programme is developed monthly and displayed in the lounge. The service receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families. The residents and families interviewed spoke positively about the activities programme. The programme is comprehensive and includes van outings, church services, daily exercises, flower arranging and going out for meals. Residents are supported to achieve activities such as setting and clearing tables, folding towels and going to the supermarket. There are resources available for staff to use for one-on-one time with the residents and for group activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans were reviewed at least six monthly and were updated as changes were noted in care requirements in files sampled. Care plan evaluations demonstrated the degree of achievement of goals and interventions in all files sampled. When health status changes short-term care plans are utilised and any changes to the long-term care plan was updated in files sampled. Residents and relatives feel they are well informed and kept up-to-date with changes.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The registered nurse facilitates access to other services (medical and non-medical) in consultation with the GP, and where access has occurred, referral documentation was maintained in files sampled. Residents' and/or their family/whānau interviewed reported they are involved as appropriate when referral to another service occurs.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>All chemicals are labelled with manufacturer labels. Safety data charts were available, and the hazard register identifies hazardous substances. Safe chemical handling training has been provided. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use as observed throughout the audit. Gloves, aprons, and goggles are available for staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Leslie Grove Rest Home displays a current building warrant of fitness. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and calibrated. The maintenance person is shared between the two sites and spends two days a week at the rest home. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facilities. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving in the court yards with outdoor shaded seating. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. There is a separate lounge area, which can be opened up for large functions or closed to provide privacy when required. There is a safe outside area that is easy to access.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All resident rooms are single rooms with shared ensuites. There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and hygiene. The communal toilets are well signed and identifiable and include vacant/in-use signs.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>The resident rooms are spacious and meet the resident's assessed needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient space to allow cares to take place. The bedrooms were personalised.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is a large lounge and dining room and one smaller lounge area in the rest home. The dining room is spacious and located directly off the kitchen/servery area. The furnishings and seating are appropriate for residents' needs. Residents interviewed reported they are able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.</p>
<p>Standard 1.4.6: Cleaning</p>	<p>FA</p>	<p>The service has monitored the effectiveness and compliance of cleaning and laundry policies and procedures.</p>

<p>And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>Laundry is laundered offsite. There is a separate laundry area at the hospital site where all linen and personal clothing is laundered for both sites. The dirty laundry is collected daily and returned cleaned to the rest home daily. Manufacturer's data safety charts are available. All chemicals were stored securely. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term backup power for emergency lighting is in place.</p> <p>There is a staff member on each duty that has completed first aid training. There are call bells in the residents' rooms, and lounge/dining room areas. Residents' were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	FA	<p>Leslie Groves has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The quality manager (a registered nurse) based at the sister facility is the infection control nurse with support from the clinical nurse managers and registered nurses. There is a combined infection prevention and control and health and safety meeting held monthly with the sister facility. Results from this meeting are discussed at monthly quality and</p>

<p>infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>registered nurse meetings. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Leslie Groves. The infection control (IC) coordinator has maintained her practice by attending regular updates. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facilities and alcohol hand gel is freely available throughout the facility.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least two yearly.</p>

<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The service is committed to the ongoing education of staff and residents. Education is facilitated by the infection control coordinator with support from the registered nurses. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information was provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around outbreak management and infection prevention and control has been provided in 2017 and 2018.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The quality manager is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly resident infection datasheet. The data has been monitored and evaluated monthly and annually at facility and organisational level. An outbreak in July 2017 was well managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. Policies also include managing resident behaviours, alternatives to restraint and guidance for staff in responding to challenging behaviours and resident needs. The service remains restraint-free. Staff training around restraint minimisation and management of challenging behaviours last occurred in May 2017.</p>

## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Leslie Groves Rest Home provides a culture of continuous improvement. Quality improvement plans are developed when shortfalls are identified or in response to complaints incidents, internal audits or observations and also when an opportunity is identified for improvement to services to be made (incident trends, satisfaction surveys, complaints, ideas and suggestions).</p>	<p>In August 2017, Leslie Groves rest home identified fall rates and related injuries were higher than expected and developed a project to improve the service provided to residents and reduce the fall rates. The analysis of all falls identified contributing factors and opportunities for improvement were identified. In September a staff education and information PowerPoint presentation were delivered to all staff. Staff engagement was positive and a culture of working together with a common goal was evident. Staff provided ideas for individual resident fall reduction and were encouraged to provide suggestions and ideas. Engagement was measured monthly around all aspects of falls, including location, times, staffing numbers and individual residents and there has been a significant decrease in the falls rate since the project began.</p> <p>As a result of the overall focus on reducing falls, the rate has decreased from 26.3 falls per 1000 bed days in August 2017 to between 3 and 12.4 per 1000 bed days since the project commenced.</p>

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End of the report.