

Elsdon Enterprises Limited - Highview Home & Hospital

Introduction

This report records the results of a Provisional 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:

Legal entity:	Elsdon Enterprises Limited
Premises audited:	Highview Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 6 September 2018 End date: 7 September 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:	40

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.

General overview of the audit

Highview Home & Hospital provides care for up to 41 rest home and hospital (geriatric and medical) level care residents. At the time of the audit there were 40 residents in total.

The service is currently governed by the director of the company. The service is managed by a facility manager who commenced in the role in late 2017. The facility manager is supported by a full-time nurse manager and a quality manager. Residents and family members interviewed spoke positively of the services provided at Highview Home & Hospital.

A provisional audit was conducted to assess a prospective new owner for Highview Home & Hospital and to assess the current status of the service prior to purchase. This audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

This provisional audit included an interview with the prospective owner. The prospective owner currently owns four other aged care facilities and has policies and processes in place around the understanding of consumer rights. The prospective owner stated that there were no planned changes to management or clinical systems, policies or procedures, changes to staff and no plans at this stage to make changes to the environment.

The provisional audit identified areas for improvement around annual performance appraisals, mandatory education/training and care planning.

Consumer rights

The facility provides care in a way that focuses on the individual resident. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

Organisational management

The service is managed by a facility manager who has worked in the role for the past year. The facility manager is supported by a nurse manager, quality manager, registered nurses and other care staff. Business plan objectives/goals provide direction. The quality management system is being implemented. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings are held to discuss quality management processes. Residents' meetings are held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An annual education and training schedule is in place. Highview Home & Hospital has job descriptions for all positions that include the role and responsibilities of the position. There is a roster that reflects sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

The service has assessment processes and residents' needs are assessed prior to entry. There is a pack available for residents and families/whānau at entry. Assessments, resident care plans, and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in resident care. The activities team implements the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. There are regular entertainers, outings, and celebrations. There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. Medication charts have photo identification and allergy status noted. Medication charts are reviewed three monthly by the general practitioner. The food service is contracted to an external company. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

Safe and appropriate environment

There were documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current warrant of fitness. Resident rooms and bathroom facilities are spacious. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating. All communal areas within the facility are easily accessible. The outdoor areas are safe and easily accessible and provide seating and shade. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. There is one person on duty at all times with a current first aid certificate. Housekeeping/laundry staff maintain a clean and tidy environment. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. Personal laundry is completed on-site by care staff and larger items are sent to a contracted laundry service daily.

Restraint minimisation and safe practice

Highview Home & Hospital has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there were five residents using restraints and one resident using an enabler. Resident files reviewed of residents with restraint evidenced a restraint risk assessment, consent form and three-monthly evaluations. Staff receive training in restraint minimisation.

Infection prevention and control

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (registered nurse) is responsible for coordinating and providing education and training for staff. The infection control coordinator has attended external training. The infection control manual outlined the scope of the programme and included a range of policies and guidelines. Surveillance data is collected and collated. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections.

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	48	0	1	1	0	0
Criteria	0	99	0	1	1	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with seven care staff (two registered nurses (RN), four caregivers and one diversional therapist) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Seven residents (five rest home and two hospital) and four relatives (one rest home and three hospital) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.</p> <p>The prospective owner currently owns four other aged care facilities and has policies and processes in place around the understanding of consumer rights.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General written consents are obtained on admission. Specific consents are obtained for specific procedures such as influenza vaccine. All seven resident files contained signed consents.</p>

		An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. Seven long-term resident files reviewed had signed admission agreements.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
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 open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping and attending cafés, and restaurants. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.
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 register has been maintained. There has been one recent complaint made in 2018. There was documented evidence of response and follow-up, however the complaint is still open. Residents

		and family members 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 service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code. Monthly resident meetings provide the opportunity to raise concerns. An annual residents/relatives' satisfaction survey is completed.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has last been provided in July 2018.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	There is a Māori health plan and ethnicity awareness policy and procedure. The policy includes references to other Māori providers available and interpreter services. The Māori health plan identifies the importance of whānau. At the time of audit there were no residents that identified as Māori. The service has established links with local Māori Moana House who provide advice and guidance on cultural matters. Staff interviewed confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff training around cultural safety has last been provided in March 2018.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise	FA	An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan.

and respect their ethnic, cultural, spiritual values, and beliefs.		Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities, and staff sign a copy on employment. The staff meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the facility manager, nurse manager, RNs and caregivers confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The facility manager, nurse manager, quality manager and staff are committed to providing services of a high standard, based on the service philosophy of care. All residents and families interviewed spoke positively about the care and support provided. Monthly staff and residents' meetings are conducted. Staff have a sound understanding of principles of aged care and stated that they feel supported by management. Care staff complete competencies relevant to their practice. 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, and the requirement to attend orientation and on-going in-service training. The quality manager is responsible for coordinating the internal audit programme.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the health status of residents and incidents/accidents, and twelve incident forms reviewed confirmed this. Resident/relative meetings are held monthly. The management team have an open-door policy. 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>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>Highview Home & Hospital provides care for up to 41 rest home and hospital (geriatric and medical) level care residents. At the time of the audit there were 40 residents in total. There were 22 rest home residents including three on young persons with disability (YPD) contracts who were all located together. There were 18 hospital residents including one resident on respite care. All other residents were under the aged related residential care (ARRC) contract. There are 22 dedicated rest home beds, nine dedicated hospital beds and 10 dual-purpose beds. At the time of the audit, there were 10 hospital level residents in dual-purpose rooms. All the dual-purpose beds are located downstairs.</p> <p>The service is currently governed by the director of the company. The service is managed by a facility manager who commenced in the role in late 2017 after previously managing the accounts for Highview Home & Hospital. The facility manager has attended the local DHB aged care meetings and has a working knowledge of DHB agreements and the health and disability standards. The facility manager is supported by a full-time nurse manager and a quality manager. The clinical manager has been in the role for 3 months and has been working as a nurse in NZ for 9 years. The facility manager provides a monthly report to the director on all aspects of service delivery at Highview Home & Hospital. The facility manager and director communicate on a regular basis. There is a business plan covering 2017 and 2018, which identifies business objectives/goals. A review of the business objectives/goals for 2017 was completed in March 2018.</p> <p>The facility manager has completed at least eight hours of professional development related to managing an aged care facility.</p> <p>This provisional audit included an interview with the prospective owner. The prospective owner currently owns four other aged care facilities since 2000. The prospective owner stated that there were no planned changes to management or clinical systems, policies or procedures. The prospective new owner will continue current memberships with established professional bodies.</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>	<p>FA</p>	<p>The nurse manager provides cover during a temporary absence of the facility manager, with the support from the quality manager and care staff.</p> <p>The same arrangement will continue in the event of temporary absence of the prospective new owner.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Highview Home & Hospital has a documented quality management system. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service has in place a range of policies and procedures to support service delivery that are developed by an external consultant and reviewed regularly. Staff interviewed confirmed they are made aware of new/reviewed policies. Quality data trends analysis related to incident and accidents, infection control, restraint and complaints are collected. Meeting minutes reviewed included discussion around quality data trends analysis.</p> <p>There are monthly adverse event reports (accident/incident data) provided around falls, skin tears, pressure injuries and medication error incidents. The quality manager ensures that the internal audit schedules are implemented. Corrective action plans were developed, implemented and signed off for any improvements identified. Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. Quality improvement data is discussed at monthly quality and staff meetings and issues identified and followed up. There are monthly residents' meetings conducted and families are invited to attend.</p> <p>There are resident/relative surveys conducted and analysed. The May 2018 resident/relative survey evidenced high overall satisfaction with the service. Corrective actions have been established and completed in areas where quality improvements were identified. A health and safety programme is in place that meets legislative requirements. A diversional therapist is the health and safety representative (interviewed). Health and</p>

		<p>safety is discussed at the monthly quality and staff meetings. Hazard identification forms and a hazard register reflect the regular monitoring of hazard controls. There is an up-to-date hazard register in place that was last reviewed on 18 July 2018. Falls prevention strategies are in place that include the analysis of falls incidents, sensor mats for relevant residents and the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>The prospective new owner stated that there were no planned changes to the current quality management system or policies and procedures. The current director will be available to mentor the prospective new owner to the quality management system.</p>
<p>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.</p>	<p>FA</p>	<p>The service collects incident and accident data and reports aggregated figures monthly to the quality and staff meetings. Staff interviewed confirmed that incidents and accidents were discussed with them. Twelve incident forms reviewed for August and September 2018 demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for two unwitnessed falls with a potential head injury. Discussions with the director and facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 incident notifications completed since the last audit. A norovirus outbreak in June 2018 was notified to the public health authorities.</p>
<p>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.</p>	<p>PA Moderate</p>	<p>Recruitment policy and procedures describes the appointment process. Seven staff files selected for review (one facility manager, one clinical nurse manager, one quality manager, one RN, two caregivers and one diversional therapist) included evidence of the recruitment process including police vetting, signed employment contracts, job descriptions and reference checks. Missing was evidence of the completion of all annual performance appraisals. The orientation package provides information and skills around working with residents with rest home and hospital level care needs. Staff interviewed stated that new staff are</p>

		<p>adequately orientated to the service.</p> <p>There is an annual in-service education and training calendar schedule, however there was no documented evidence of mandatory two-yearly training being completed for open disclosure, complaints, spirituality/counselling, sexuality/intimacy, informed consent/EPOA and advanced directives. There are seven RNs (including the clinical nurse manager) and three have completed interRAI training. Medication competencies are up-to-date. Current annual practising certificates were sighted for the registered health professionals.</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>There is a documented rationale for staffing the service. The roster evidenced an increase in staffing to meet increased occupancy and resident needs. On the day of audit there were 40 residents in total (22 rest home and 18 hospital). The facility manager and nurse manager work full time from Monday to Friday and are available 24/7 for any operational and clinical issues respectively.</p> <p>In the downstairs wing there are 27 beds (20 dual-purpose) with 26 residents in total at the time of the audit, eight rest home residents and 18 hospital residents. There is one RN on duty on the morning and afternoon shifts, and on the night shift. They are supported by five caregivers (three long and two short shifts) on the morning, three caregivers (one long and two short shifts) on the afternoon shift and one caregiver on the night shift.</p> <p>In the upstairs wing there are 14 beds with 14 rest home residents in total, at the time of the audit. There are three caregivers (two long and one short shifts) on the morning, two caregivers (one long and one short shifts) on the afternoon shift and one caregiver on the night shift. Staff working on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the facility manager, clinical nurse manager and RNs provide good support. Residents and family members interviewed reported there are sufficient staff numbers and that management are accessible.</p> <p>The prospective owner stated there will be no changes to staff who will</p>

		transfer to the new owner on the date of settlement.
<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>	FA	Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office. Care plans and notes were legible and where necessary signed (and dated) by a RN.
<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>	FA	The service has admission policies and processes in place. Residents receive an information pack outlining services provided, the admission process and entry to the service. The quality manager in consultation with the nurse manager screens all potential residents prior to entry and records all admission enquires in a hard copy system. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the nurse manager. Seven admission agreements in use align with the requirements of the ARC contract.
<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>	FA	Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The yellow envelope system is used for transfers to the public hospital. A transfer form accompanies residents to receiving facilities. The residents and their families are involved for all exit or discharges to and from the service. The clinical nurse manager and RNs interviewed were knowledgeable in the transfer/discharge process.
<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</p>	FA	There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential

<p>practice guidelines.</p>		<p>Aged Care 2011. Registered nurses administer medications with senior caregivers checking when required. Medication education and medication competencies have been completed annually. The service uses a four-weekly medico blister pack system. All medication is checked on delivery against the electronic medication chart and any pharmacy errors recorded and fed back to the supplying pharmacy.</p> <p>All medications are stored safely. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There were no residents self-medicating on the day of audit. Standing orders were not in use. Fourteen medication charts reviewed met legislative requirements. All residents have individual medication orders with photo identification and allergy status documented. Medications had been signed as administered in line with prescription charts. Appropriate practice was demonstrated on the witnessed medication around.</p>
<p>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.</p>	<p>FA</p>	<p>The food service at Highview Home & Hospital is provided by a contracted company. The company prepares meals and delivers to Highview Home & Hospital three times a day. The food service is managed by a kitchen supervisor/senior caregiver. The kitchen supervisor is responsible for ordering additional food supplies, ensuring correct stock rotation, and kitchen cleaning. Kitchen fridge, food and freezer temperatures are monitored and documented daily. Highview Home & Hospital staff provides breakfast to residents, either in the dining room or in their rooms. The four weekly seasonal menus have been audited and approved by an external dietitian. The RNs conduct a nutritional assessment for all residents on admission and reviews each resident's dietary plan.</p> <p>Any dietary changes and interventions required such as modified, special diets or weight loss management are communicated to CIBUS Catering via fax and kitchen staff via a dietary form. A whiteboard in the kitchen records resident's individual requirements. Resident menus are individualised and include likes and dislikes, food allergies, modified dietary requirements such as vegetarian and gluten free. High protein supplements and calorie drinks are provided to residents with identified weight loss or low BMI. The contracted food company provides annual</p>

		education on safe food handling, meal presentation and dietary requirements. A satisfaction survey including food services, is completed annually. All concerns are reported to the Food Company and corrective actions taken. Residents and families interviewed were complimentary about the food service.
<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	The service records the reasons for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency if entry were declined.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	The facility has embedded the interRAI assessment protocols within its current documentation. InterRAI assessments were completed for six of the seven resident files reviewed (one resident was receiving short-term respite care). The interRAI assessment is reflected in the momentum care plan templates. InterRAI initial assessments and assessment summaries were evident in printed format in all files. Files reviewed identified that risk assessments have been completed on admission and reviewed six monthly as part of the evaluation. Additional assessments for management of mobility, pressure injury prevention, nutrition, pain, continence, behaviour, wound care and restraint were completed as required.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Care plans for long-term residents describe the individual support and interventions required to meet the resident goals. Initial risk plans are developed on admission (as applicable) to alert staff to any resident risks such as falls. The long-term care plans reflect the outcomes of risk assessment tools and the interRAI assessment. Care plans demonstrate service integration and include input from allied health practitioners. Short-term care plans were in use for changes in health status. These are evaluated regularly and either resolved, or if an ongoing problem, added to the long-term care plan. Residents/relatives interviewed

		confirmed they participate in the care planning process. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. There was evidence of service integration with documented input from a range of specialist care professionals. The YPD file reviewed enjoys lego and meccanno in his room and is actively involved with all craft activities. He visits the local library and enjoys weekly walks to the café.
<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>When a resident's condition alters, the RN initiates a review and if required, GP, NP or nurse specialist consultation. The respite file reviewed (hospital) included an initial nursing assessment and care plan. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Family notifications were documented in progress notes in the residents' files reviewed. Adequate dressing supplies were sighted.</p> <p>Wound management policies and procedures are in place. A wound assessment and wound care plan (including dressing type and evaluations on change of dressings) were in place for five skin tears, one surgical wound and three lesions. There was one stage two pressure injury on the day of audit. Wound care evaluations consistently document the progression and/or deterioration of the wounds. There is current wound specialist nurse input into the treatment of the pressure injury. Continence products are available. The residents' files include a urinary continence assessment, bowel management plan, and continence products used. Monitoring occurs for blood pressure, weight, vital signs, food and fluids, blood glucose, pain and challenging behaviours.</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>	PA Low	<p>The service employs an experienced, qualified diversional therapist who works 30 hours per week. The diversional therapist (DT) has been employed at Highview Home & Hospital for 13 years and qualified as a diversional therapist in 2016. A monthly programme is developed in consultation with residents and reflects their interests and abilities. The programme is varied and provides group and individual activities to meet the hospital, rest home and YPD resident's recreational preferences and</p>

		<p>interests. One-on-one contact is made with residents who are unable to or choose not to participate in group activities. Residents have a social profile and activities assessment completed over the first few weeks after admission, which forms the basis of a diversional therapy plan and is then reviewed. Activities plans are scheduled for evaluation six monthly. A record is kept of individual resident's activities and monthly progress notes are documented. Not all residents had the activities care plan reviewed within the required timeframes and not all residents had monthly progress notes documented.</p> <p>The resident/family/whānau/EPOA as appropriate, is involved in the development of the activity plan. Activities include (but are not limited to); exercises, walking groups, hand massages, quizzes, board games, baking, movies, sing-a-longs and pamper afternoons. Community visitors include church visitors and entertainers. There are weekly outings and drives into the community, including lunch outings and visits to special events. Once a year, the Highview bus takes residents on an annual holiday, usually to Central Otago where residents participate in jet boating, picnics and shopping trips. Resident meetings are held monthly with a volunteer advocate who hosts the meeting and provides an opportunity for residents to feedback on the service and the activities programme. Highview Home & Hospital has three residents under the age of 65. Specific interventions for these residents include weekly walking group to a local café, regular outings and set tasks assisting in the rest home wing.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long-term care plans reviewed had been evaluated by RNs six monthly, or when changes to care occurred and a new care plan generated. Residents are reassessed using the interRAI and applicable facility assessment tools. There is a one-three monthly clinical review by the medical practitioner or sooner if needs change. Medication charts are reviewed three monthly or more frequently as required. Short-term care plan evaluations are completed at weekly intervals or more often if required.</p> <p>Evaluations are conducted by the RNs with input from the resident, family, diversional therapist, caregivers and GP. Family are notified of any changes in the resident's condition, as evidenced in sampled resident files</p>

		and confirmed in family interviews. Residents and family interviewed, confirmed their participation in care plan evaluations and this is evidenced in the files reviewed. Progress notes are documented each shift and evidence regular RN reviews related to care plan goals.
<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>	FA	Referral to other health and disability services is evident in the residents' files sampled. The service facilitates access to other medical and non-medical services. There is documented evidence of referrals to a wound nurse specialist, palliative care services, podiatrist, ear health, physiotherapist, dietitian and the needs assessment coordination unit as required. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
<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>	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets were readily accessible for staff. Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training. Staff interviewed indicated a clear understanding of processes and protocols.
<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>	FA	<p>The building holds a current warrant of fitness, which expires on 20 December 2018. Fire equipment is checked by an external provider. The maintenance person undertakes preventative and reactive maintenance. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Essential contractors are available 24-hours. Hazard registers are in place for all areas.</p> <p>The facility has sufficiently wide corridors with handrails for residents to</p>

		<p>safely mobilise using mobility aids. There is a lift between floors. There is safe access to the outdoor areas. Seating and shade are provided. Residents were observed moving freely around the areas with mobility aids where required. The facility has a bus available for transportation of residents. The bus has a current warrant of fitness and vehicle registration. A bus driver is employed to drive the bus and is accompanied by a senior caregiver and/or the diversional therapist. A staff member with a current first aid certificate is available for all bus trips.</p> <p>The prospective owner advised there are no plans at this stage to make changes to the environment except continuing with ongoing maintenance.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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>	FA	<p>All resident rooms have hand-washing facilities. There are sufficient communal toilets and showers to meet resident requirements. All communal toilets and bathrooms have appropriate signage and locks on the doors. Fixtures, fittings and flooring is appropriate. Communal, visitor and staff toilets are clearly identifiable, equipped with locks and flowing soap and paper towels.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The rest home and hospital resident rooms are spacious enough to allow residents to move about the furnishings with mobility aids, wheelchairs and standing or lifting hoist. Residents and families are encouraged to personalise their rooms as viewed on the day of audit. Residents were observed safely moving around the facility.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Highview Home & Hospital has a large lounge and dining room area downstairs and another combined smaller one upstairs. A separate small quiet lounge is also available downstairs. Residents and assistants are able to move freely. Activities occur throughout the facility and residents interviewed stated they were able to use alternative communal areas if they did not wish to participate in communal activities being held in one of these areas.</p>

<p>Standard 1.4.6: Cleaning 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>FA</p>	<p>Highview Home & Hospital has policies and procedures in place for laundry and cleaning services. Product information and safety datasheets are available for all chemicals in use. All chemicals are securely stored. Staff receive training at orientation and through the in-service programme. All chemicals were clearly labelled. Protective personal equipment is available in the sluice and laundry. The laundry area is located behind the building and not accessible to residents. Personal laundry is sorted for washing and is processed by the housekeeper. Larger items such as sheets are processed by a contracted company who pick up and deliver. There are colour coded linen bags and all linen and personal clothing items are sorted prior to washing. Residents and relatives reported satisfaction with the laundry services.</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>	<p>FA</p>	<p>There is an emergency/disaster management plan in place to ensure health, civil defence and other emergencies are included. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service on 4 October 2002. Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 27 March 2018. Fire training and security situations are part of orientation of new staff and include competency assessments. There are civil defence and first aid kits available that are checked annually.</p> <p>There are adequate supplies in the event of a civil defence emergency including sufficient food, water, blankets and alternate gas cooking facilities (BBQ and portable gas hob) available. The facility has emergency lighting and torches. All RNs employed have up-to-date first aid certificates. Smoke alarms, sprinkler system and exit signs are in place in the building. The call bell system is available in all resident areas, (ie, bedrooms, ensuite toilet/showers, communal toilets, dining rooms). 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</p>	<p>FA</p>	<p>General living areas are heated via large heat pumps and resident rooms are appropriately heated with individual heaters. All resident rooms have external windows and are well ventilated. The facility has plenty of</p>

and comfortable temperature.		natural light. All residents interviewed, stated they were happy with the temperature of the facility. Smoking is only allowed outside in designated areas. Residents and family interviewed stated they were happy with temperature management.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the quality management system. A RN is the designated infection control coordinator. The infection control team is included as part of the staff meetings. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. Visitors are asked not to visit if they have been unwell. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. A norovirus outbreak in June 2018 was reported to public health and was managed well.
<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>	FA	Infection control is managed by the infection control coordinator (RN). The infection control coordinator has maintained current knowledge of infection prevention and control. The infection control coordinator has access to infection control personnel within the district health board, laboratory services and the GP.
<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>	FA	The infection control manual outlines a range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed.
Standard 3.4: Education	FA	The infection control policy states that the facility is committed to the

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>ongoing education of staff and residents. Formal infection control education for staff has occurred. Staff receive education on orientation and one-on-one training as required. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to visitors that is appropriate to their needs. Resident education occurs at resident meetings such as use of sanitisers and hand washing. Hand hygiene posters have been placed in all resident toilet areas.</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 is an integral part of the infection control programme and is described in the infection control policy. Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Corrective actions are established where trends are identified.</p> <p>Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager and clinical nurse manager. There has been one norovirus outbreak since the previous audit.</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>At the time of the audit, there were five residents using restraints (bedrails) and one resident using an enabler (bedrail). All necessary documentation is available in relation to the restraints. Staff training has been provided around restraint minimisation in July 2018. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of</p>

and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		restraint and monitoring requirements.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	The restraint coordinator, in partnership with the RNs, GP, resident and their family/whānau, undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Three residents' files where restraint was in use were reviewed, and contained completed assessments. The completed assessments considered those listed in 2.2.2.1 (a) - (h).
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Monitoring is documented on a specific restraint monitoring form and reflects the actual times monitoring occurred, evidenced in three resident files reviewed where restraint was being used.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). A review of three resident files identified that evaluations are up-to-date.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	The restraint minimisation programme is discussed and reviewed at the monthly quality meeting. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme, and staff education and training. Annual internal audits of restraint practices are also completed.

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>There is an annual in-service education and training calendar schedule, however there was no documented evidence of mandatory two-yearly training being completed for open disclosure, complaints, spirituality/counselling, sexuality/intimacy, informed consent/EPOA and advanced directives. Seven staff files selected for review (one facility manager, one clinical nurse manager, one quality manager, one RN, two caregivers and one diversional therapist) included evidence of the recruitment process including police vetting, signed employment contracts, job descriptions and reference checks. Missing was evidence of the completion of all annual performance appraisals</p>	<p>(i)Not all mandatory education/training has been completed within the required two-year period. Education not completed includes; open disclosure, complaints, spirituality/counselling, sexuality/intimacy, informed consent/EPOA and advanced directives. (ii) Seven staff files were reviewed, and three of seven files did not have documented evidence of an up-to-date annual performance appraisal</p>	<p>(i)Ensure that the annual education planner is implemented, and education is provided to cover all mandatory two-yearly training requirements. (ii) Ensure that all performance appraisals are completed annually</p> <p>90 days</p>

<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>The diversional therapist completes the activities assessments and activities care plans in consultation with the resident or their family. Not all residents had an activity care plan reviewed six monthly. The diversional therapist records participation on a monthly activity record and progress notes document special interests and preferences monthly, however not all progress notes evidenced entries.</p>	<p>i) Three of the six long-term residents (two rest home and one hospital) did not have progress notes documented at least monthly.</p> <p>ii) Four of the six long-term residents (one hospital, one YPD, two rest home) who were due for a six-monthly activities care plan review, had not had the activities care plan reviewed six monthly.</p>	<p>i) Ensure that all residents have progress notes documented monthly.</p> <p>ii) Ensure that the activities care plan is evaluated against the resident goals within the required timeframes.</p> <p>90 days</p>

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, there 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.