

Elsdon Enterprises Limited - Highview Home & Hospital

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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: 7 July 2021 End date: 7 July 2021

Proposed changes to current services (if any): There are 26 rooms on the ground floor of which 7 are rest home only. The service has requested three of the seven rooms be verified as suitable as dual-purpose. There are currently 13 rest home rooms on the first floor (including one double room). The service has requested all 13 rooms be verified as dual purpose including the one double room (up to 14 residents). Overall bed numbers would remain at 41 beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 38

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 Rest Home provides rest home and hospital (medical and geriatric) level care services for up to 41 residents. On the day of audit there were 38 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures where relevant, the review of residents and staff files, observations and interviews with residents, relatives, the manager, and staff.

A concurrent partial provisional audit was also completed to assess the suitability of the service to reconfigure rest home beds to dual-purpose beds. This included changing 17 rest home level beds as suitable for dual-purpose (rest home/hospital level). This audit identified that not all were appropriate as dual-purpose, and changes needed to be made to certain rooms for them to be certified as dual-purpose.

The facility manager was new to the role October 2020. She has a background with the Public Trust. She is supported by a clinical manager/RN. The clinical manager has been in the role since February 2021 and is an experienced registered nurse. The management team are supported by the organisation's operations manager. Residents and relatives interviewed overall spoke positively about the care and support provided.

The service has addressed two of the nine previous audit shortfalls around complaint management and review of restraint. Further improvements continue to be required around quality programme, education, staffing, interRAI timeframes, implementation of care, food service and call bells. This surveillance audit identified further shortfalls around open disclosure, quality plan, corrective actions, incident forms, documentation, and preventative maintenance.

The partial provisional audit identified improvements required around increasing staffing pool, medication management, sluice, equipment, resident rooms, laundry, and fire evacuation.

Consumer rights

Residents and families are made aware of the complaints process. Verbal and written complaints are recorded in a complaint register.

Organisational management

The quality and risk management programme includes a service philosophy and goals. Incidents and accidents are reported and investigated. An education and training programme is documented. Appropriate employment processes are adhered to and employees have a staff appraisal completed on an annual basis.

Continuum of service delivery

The registered nurses complete interRAI assessments, and care planning. Care plans demonstrate service integration. Short term care plans are completed for changes in health status. Care plans are reviewed at least six-monthly.

The activity programmes meet the abilities and needs of residents. There is provision for group and individual one-on-one activities. The activity programmes meet the abilities and recreational needs of the groups of residents. Residents interviewed spoke positively around activities.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies. The general practitioner reviews the electronic medicine charts at least three-monthly.

All meals and baking are cooked on site. Individual and special diets are accommodated. Residents interviewed responded favourably to the food provided.

Safe and appropriate environment

Partial Provisional: Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff and was seen to be worn by staff when carrying out their duties on the day of audit.

The building holds a current warrant of fitness, which expires on 20 December 2021. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and tagged and calibrated. The maintenance person is new to the role and works four hours a day. There is a lift between floors that is large enough for a tilted ambulance stretcher. Advised that if residents need to be transported from upstairs in a prone position then they are transported down the fire escape.

All resident rooms have hand-washing facilities. There are sufficient communal toilets and showers on both floors to meet resident requirements including mobility equipment. Highview Rest Home has a large lounge and dining room area on the ground floor that would manage the increase in hospital residents. There is another smaller lounge upstairs and a separate dining area upstairs.

The upstairs communal areas would be stretched if all 14 resident's upstairs were hospital level. The laundry area is located outside behind the building and not accessible to residents, with two commercial washing machines and two commercial dryers. The area between the laundry and main building is covered but not fully enclosed to the elements. Currently all linen and personal laundry is laundered on site by the cleaning staff and healthcare assistants.

There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence, or other emergencies. Civil defence supplies, adequate food and water including ceiling tanks, and a gas barbeque for alternative cooking are available. Six monthly fire drills are held.

All 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.

Restraint minimisation and safe practice

The service has documented systems in place to ensure the use of restraint is actively minimised. There are currently no residents with restraint and seven residents with an enabler (bedrails). The clinical manager is the designated restraint coordinator.

Infection prevention and control

The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. While the responsibility of infection control is clearly defined, this is not being fully implemented. The clinical manager is the designated infection control coordinator. 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.

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	11	0	9	7	0	0
Criteria	0	40	0	13	9	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance. Information about complaints is provided in the entry pack of information presented to prospective residents and families. Interviews with residents and families demonstrated their understanding of the complaints process. They confirmed that issues are addressed promptly, and that they feel comfortable to bring up any concerns. The complaints process is linked to the quality and risk management system.</p> <p>Verbal and written complaints are recorded in a complaint register. There were three complaints logged in the register for 2020-2021 (year to date). All complaints reflected evidence of being resolved and follow up documentation. This is an improvement on the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p>	PA Low	<p>Seven residents interviewed (three rest home, four hospital) stated they were welcomed on entry and were given time and explanation about the services provided. Accident/incidents and open disclosure processes alert staff of their responsibility to notify family/next of kin of any accident/incident and to ensure full</p>

<p>effective communication.</p>		<p>and frank open disclosure occurs. Eighteen incident/accident forms reviewed from May and June identified that family notification was not consistently being documented. Three hospital families interviewed confirmed that they are notified of any changes in their family member's health status or if there is an adverse event.</p> <p>Interpreter services are available if required.</p>
<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>	<p>FA</p>	<p>Elsdon Enterprises (Ltd) are the proprietors of Highview Home and Hospital. The organisation owns three other facilities in Otago and one facility in Canterbury.</p> <p>Highview Home & Hospital provides care for up to 41 rest home and hospital (geriatric and medical) level care residents. There are 22 dedicated rest home beds and 19 dual-purpose beds. At the time of the audit there were 38 residents. There were 18 hospital residents and 20 rest home residents including one resident on respite and one resident on a younger person on a residential disability contract. The remaining residents were under the age-related residential care (ARRC) contract.</p> <p>The facility manager was new to the role October 2020. She has a background with the Public Trust. She is supported by a clinical manager/RN. The clinical manager has been in the role since February 2021 and has a background in Hospice and ICU nursing. The management team are supported by one of the Director's (operations manager) who provides oversight to the facility and meets regularly with the management team.</p> <p>The service has a generic continued improvement policy, quality indicators, mission, philosophy statement, and generic goals/objectives (link 1.2.3.1). The business plan is dated 2020-2021.</p> <p>The manager has undertaken training relating to her management role and has completed a minimum of eight hours within her first year of employment at Highview.</p> <p>Partial Provisional:</p> <p>There are 26 rooms on the ground floor of which seven are rest home only. The service has requested three of the seven rooms be verified as suitable as dual-purpose. There are currently 13 rest home rooms on the first floor (including one double room). The service has requested all 13 rooms be verified as dual-purpose including the one double room (up to 14 residents). This audit identified that not all</p>

		were appropriate as dual-purpose, and changes needed to be made to certain rooms for them to be certified as dual-purpose (link 1.4.4.1). On level one, rooms 215, 216 and 219 and the double-room (214) were verified at this audit as large enough for hospital (dual-purpose) level care.
<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	In the absence of the manager, the clinical manager is in charge. The clinical manager is supported by a team of registered nurses and the operations manager.
<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>	PA Moderate	<p>A quality and risk management programme is documented, however there are generic goals/objectives. A system of document control is in place. Policies are scheduled to be reviewed two yearly and this is being monitored by the manager.</p> <p>The monthly collating and analysis of quality and risk data includes monitoring accidents and incidents and infection rates. Trends in data are not routinely communicated to staff.</p> <p>There have been two staff meetings documented in 2021 (YTD). There was no documented evidence that quality data (including complaints, adverse events, infection surveillance and internal audit results) have been shared at those meetings. There is no current established quality meeting or committee responsible for implementing the quality programme.</p> <p>There is an internal audit schedule and internal audits regularly monitor compliance. Internal audits have been completed in 2021 as per schedule. It was noted that 10 of 12 were 100% including the care plan audit which was completed by the manager (non-clinical). The two internal audits that had corrective actions did not identify whether the corrective actions were implemented or evaluated for effectiveness. A resident satisfaction survey for 2021 is currently in the process of being completed. The 2020 satisfaction survey results could not be located by the new manager, noting a review of 2020 meeting minutes did not reflect feedback on survey results.</p> <p>There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. Health and safety is overseen by the operations manager and manager. Health and safety training</p>

		<p>begins during staff induction and was last completed 16 April 2021. Advised that Health & Safety meetings were completed April 2021, but minutes could not be located (last meeting minutes dated 25 September 2019). A H&S meeting is scheduled for July 2021. There is no documented evidence that H&S has come through other meetings in 2021. There is a current hazard register which has been reviewed June 2021.</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls.</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>PA Moderate</p>	<p>There is an accidents and incidents reporting policy. A registered nurse conducts a clinical follow-up of each adverse event. The clinical manager investigates accidents and near misses and analyses results (link 1.2.3.6). Eighteen incident forms reviewed (May/June 2021) demonstrated that an investigation occurred following each incident. However, incident forms were not always fully completed. Neurological observations were completed for unwitnessed falls or if there was a suspected injury to the head.</p> <p>Discussion with the managers confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. One section 31 was completed in regard to the current registered nurses' shortage across aged care.</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>There are human resource management policies in place. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience, and veracity. A copy of practising certificates for health professionals is maintained. Six staff files were reviewed (clinical manager, two RNs, two HCAs, two maintenance). The service has implemented an orientation programme that provides new staff with relevant information for safe work practice.</p> <p>Of the current Healthcare assistants (HCA) there is one HCA with a level four qualification, two have level three, four have level two and there are four foreign trained registered nurses. Healthcare assistants can access NZQA qualifications through Skill Set.</p> <p>The service has implemented Care training online for staff. However, this is not monitored and therefore uptake of this training has been limited by staff. In</p>

		<p>2020/2021 YTD the following training sessions have been provided; hand hygiene, fire & H&S, infection control/Covid, manual handling/falls, documentation, and medications. Numbers of staff that have attended is low. Training records reviewed by healthcare assistants and registered nurses identified limited education completed by staff in the last year. There is a 2021 education plan. The registered nurses are able to attend external training including sessions provided by the DHB. One RN has attending a wound care training day. Two RNs have attended palliative care training. Two of seven RNs have completed their interRAI training. Annual staff appraisals were evident in all staff files reviewed (where applicable). There is a minimum of one trained first aider on every shift and this is an improvement on previous audit.</p> <p>Partial Provisional: Discussions with the manager confirmed they are currently advertising and interviewing for more staff. They are planning to employ a further two registered nurses and four healthcare assistants.</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>PA Moderate</p>	<p>There is a documented rationale for staffing. The manager and clinical manager/RN both work full time (Monday to Friday) and are available 24/7 for any operational and/or clinical issues. There is one RN rostered for each shift. Interviews with three healthcare assistants all stated that there has been a high turnover of staff and there have been times when they have been working short staff. Relatives interviewed stated there had been examples where they were short staffed on weekends, but this has since improved in the last month. A review of the roster for the last three weeks did not evidence shifts not being replaced. Residents and relatives interviewed overall stated staff were busy and felt staffing levels could be better.</p> <p>Ground Floor (7 rest home, 18 hospital)</p> <p>AM shift: Clinical Manager 0800 – 1630 Monday – Friday RN 0700 – 1500 Wednesday/Thursday, Friday and 0700 -1900 Saturday/Sunday HCAs 2x 0700 – 1500, 1x 0800 – 1400, 1x 0700 – 1130</p> <p>PM shift: RN 1500 – 2300 or 1830 – 2300 HCAs 1x 1500 – 2300, 1x 1500 – 2200, 1x 1700 – 2100 RN 2300 – 0700</p>

		<p>HCA 1x 2300 – 0700</p> <p>Level one: (13 rest home)</p> <p>HCA 1 x 0700 – 1500, 1x 0700 – 0900, 1x 0500 – 0700</p> <p>PM Shift: 1x 1500 – 2300</p> <p>Night: HCA/housekeeping 2300 – 0500</p> <p>Partial Provisional: With the increase in hospital beds on level one there will be an extra RN rostered on level one 0700 – 1500 and 1500 – 2300.</p> <p>An extra healthcare assistant is rostered 0700 – 1500 and 1500 – 2300 and caregiver 2300 – 0700 (link 1.2.7.3).</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>	PA Low	<p>Care plans and progress notes are paper based. All had been signed and dated by the writer which included designation. However, hand writing in many places of the care plan were difficult to read.</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>	PA Low	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with current legislation. The service uses a fortnightly robotic roll system. All medication is checked on delivery against the electronic medication chart and any pharmacy errors are recorded and fed back to the supplying pharmacy. All eye drops, and ointments sighted were dated on opening. The medication fridge and staffroom are maintained within the acceptable temperature range. The controlled drugs are checked weekly with two RNs.</p> <p>RNs administer medications on the ground floor (hospital and rest home residents) and HCAs with medication competencies administer medications upstairs (rest home level only). Medication competencies have been completed annually and medication education is provided (link 1.2.7.5). Competencies include insulin, warfarin, and syringe drivers. Appropriate practice was demonstrated on the witnessed medication round. Although it was noted the nurse administering the medication was distracted frequently. The service could consider using specific aprons during medication rounds that state “Medication round - please do not</p>

		<p>disturb”.</p> <p>Ten medication charts reviewed met legislative requirements. All residents had individual medication orders with photo identification and allergy status documented. Medications had been signed as administered in line with prescription charts. Indications for use were documented with all medications. There were no residents self-medicating on the day of audit. Standing orders were not in use.</p> <p>Partial Provisional & Surveillance: Medications are stored in locked medication trolleys which are stored in the dining room on both floors. There is no separate medication/treatment room and very little bench space. There is a cupboard in the nurse’s office on the ground floor that stores impress stock. This cupboard has a broken lock and was not secure. Robotic packs are also kept in a locked cupboard in the nurse’s office.</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>	<p>PA Low</p>	<p>There is a small but well-functioning centrally located kitchen. All meals are cooked on site for the facility. A food control plan is in place and expires 31 August 2021.</p> <p>Food is served from the kitchen to the adjacent ground floor dining area. There is a satellite kitchenette on level one adjacent to the dining room where meals are served to residents. Meals are delivered to the upstairs servery on trolleys. Food temperatures are taken before meals are taken upstairs.</p> <p>A nutritional assessment is made by the RN as part of the initial assessment on admission, and this includes likes and dislikes. Nutritional assessments were evident in a folder for kitchen staff to access. This included consideration of any dietary needs (including cultural needs). This was reviewed six-monthly as part of the care plan review or sooner if required. Residents on a weight loss plan or special diets are highlighted in the kitchen. The menu is a four-weekly seasonal menu. The menu has been reviewed by a registered dietitian. There was evidence of residents receiving supplements, as prescribed by the GP. Fridges and freezer temperatures are monitored and recorded daily in the kitchen. Food in the kitchen fridge was covered and dated but not in the upstairs kitchenette fridge. Cleaning schedules are maintained and signed by staff. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Soft and pureed dietary needs were documented in files sampled. Feedback on the food service is given at the resident meetings. Residents interviewed were</p>

		complimentary of the food service.
<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>	<p>PA Moderate</p>	<p>When a resident's condition alters, the RN initiates a review and if required, alerts the GP. There is evidence of GP review following a change in a resident's condition, in files reviewed. There is evidence that relatives were notified of any changes to resident health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. However, not all relatives were notified of accidents/incidents their relatives had, as evidenced in the incident forms reviewed (link 1.1.9.1). Relative notifications were documented in progress notes of resident files reviewed.</p> <p>The service utilises a care plan template which has limited space to fully personalise the resident care plan especially for those residents with comorbidities and increased support needs. Not all care plans reviewed identified interventions to support all assessed needs.</p> <p>Continence products are available. The residents' files include a continence assessment and continence products used. Monitoring occurs for (but not limited to) blood pressure, weight, vital signs, food and fluids, blood glucose, pain, turning charts, and challenging behaviours.</p> <p>Wound management policies and procedures are in place. Adequate dressing supplies were sighted. A wound assessment and wound care plan (including dressing type and evaluations on change of dressings) were in place for two pressure injury wounds. There was one unstageable pressure injury and one stage 2 pressure injury on the days of audit. The wound specialist nurse is available when required and a referral has been sent for the unstageable pressure injury to be assessed</p> <p>Improvement Note: The service should consider updating the wound management template to include a specific area around treatment instructions rather than at each evaluation.</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</p>	<p>FA</p>	<p>Highview Rest Home employs an experienced, qualified diversional therapist who works 27.5 hours per week (5.5 hours over five days). The diversional therapist (DT) has been in the role for 17 and a half years and qualified as a diversional therapist in 2016. A weekly programme is developed in consultation with residents</p>

<p>service.</p>		<p>and reflects their interests and abilities. The programme includes twice-weekly van outings where they go on drives to places of interest, as requested by residents. The programme is varied and provides group and individual activities to meet the hospital, rest home and younger resident's recreational preferences and interests. Entertainment and music are available fortnightly at Highview Rest Home. The diversional therapist has been focusing on more one-on-one sessions with the residents, based on their preference. Residents have an activities assessment completed over the first few weeks after admission, which forms the basis of a diversional therapy plan and is then reviewed on a six-monthly basis. Activities assessments and evaluations were evidenced as being completed in resident's files reviewed. The resident/family/whānau/EPOA as appropriate, is involved in the development of the activity plan. Progress notes are maintained on a monthly basis. A record is kept of individual resident's activities.</p> <p>Activities include (but are not limited to); two-weekly van rides, fortnightly entertainers, group activities including baking and crafts, housie, quizzes and news reading. A group of residents are currently fundraising for a holiday at the end of the year to central Otago that the diversional therapist is helping to organise.</p> <p>One-on-one contact is made with residents who are unable to or choose not to participate in group activities. These activities include nail cares, facials, the DT has a chat with the resident, and reading books. Feedback on the activities programme is provided at resident meetings and by verbal feedback.</p> <p>The residents interviewed are happy with the current activities and enjoy the van outings.</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 (link 1.3.3.3). Evaluations are conducted by the RNs with input from the diversional therapist and GP. An evaluation form is used to evaluate the care plan. Relatives are notified of any changes in the resident's condition, as evidenced in sampled resident files and confirmed in relative interviews. Short-term care plans are evidenced as being completed as necessary in resident's files reviewed. Short-term care plans were evaluated and added to the long-term care plan as required, in resident files reviewed. Progress notes are documented each shift and evidenced regular RN reviews related to care plan goals or when a resident's condition changed. There is a three-monthly clinical review by the GP, or sooner if needs change. Residents and relatives interviewed, confirmed their</p>

		participation in care plan evaluations and this was evidenced in the files reviewed.
<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>	PA Low	<p>There are documented processes for the management of waste and hazardous substances in place. Safety datasheets were readily accessible for staff. Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff and was seen to be worn by staff when carrying out their duties on the day of audit. Staff interviewed indicated a clear understanding of processes and protocols. There is a sluice behind a cupboard on level one. This was out of order at the audit but fixed following the audit and is now functioning. There is a sluice on the ground floor.</p> <p>It was noted that a number of commodes are used in resident rooms at night. Neither sluices have a sanitiser and with the increased use of commodes and hospital residents this should be considered.</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>	PA Low	<p>Surveillance & Partial Provisional: The building holds a current warrant of fitness, which expires on 20 December 2021. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and tagged and calibrated. Essential contractors are available 24-hours. The maintenance person is new to the role and works 4 hours a day. While reactive maintenance is completed there is no current documented preventative maintenance plan. Fire equipment is checked by an external provider. The carpet in the lounge area has rolled and advised that this is to be stretched next week.</p> <p>Residents were observed to mobilise safely within the facilities. There are sufficient seating areas throughout the facilities. There have been refurbishments made to the main to the managers and DT offices and entrance to the ground floor lounge, with further renovations planned. There is safe wheelchair access to all communal areas. There is a lift between floors that is large enough for a tilted ambulance stretcher. Advised that if residents need to be transported from upstairs in a prone position then they are transported down the fire escape.</p> <p>The exterior has been well maintained with safe paving, outdoor shaded seating, lawn, and gardens. There is a designated smoking area and an outside patio.</p> <p>Healthcare assistants interviewed confirmed there have been issues with equipment. Since the draft report the manager advised that all equipment on the</p>

		day of audit was working, it is unfortunate in this current Covid environment that some items take time to arrive.
<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>	FA	<p>Partial Provisional: All resident rooms have hand-washing facilities. There are sufficient communal toilets and showers on both floors to meet resident requirements including mobility equipment. All communal toilets and bathrooms have appropriate signage, however a number had broken locks on the doors (link 1.4.2.1). 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</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	PA Low	<p>Partial Provisional: The original Highview rest home is an old villa. There are a number of large rooms and much smaller rooms.</p> <p>Ground floor: There are currently 26 resident rooms. Nineteen are currently dual-purpose and seven are rest home only. One of the rest home rooms is a small double room shared by two brothers. While this room is not verified as a double room, it has been approved previously for these two brothers to be together. Both brothers are rest home level and mobile. There are three further rooms downstairs (109, 111, 112) that were reviewed as part of this audit but were verified as not suitable for hospital level due to the small size of these rooms.</p> <p>Level one: There are currently 13 rest home rooms upstairs with one double room (currently rest home only). The double room (214) is used by a married couple and has been verified as suitable for a couple (dual-purpose). Rooms 215, 216 and 219 were verified at this audit as large enough for hospital (dual-purpose) level care. Rooms 202-207, 209-211 were reviewed at this audit but assessed as not suitable due to the small size and current furnishings taking up too much space. The service would have to determine how best to provide storage space as well as furniture to make the room suitable for hospital level care. There are handrails around hallways and up raised ramps.</p> <p>Residents and relatives are encouraged to personalise their rooms as viewed on the day of audit.</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>Partial Provisional: Highview Rest Home has a large lounge and dining room area on the ground floor that would manage the increase in hospital residents. There is another smaller lounge upstairs and a separate dining area upstairs. The upstairs communal areas would be stretched if all 14 residents' upstairs were hospital level (link 1.3.13.1). Advised that some of the hospital residents may stay in their rooms or come downstairs to the larger lounge if they wished. Residents were currently able to move freely with mobility aids in both areas. Activities occur throughout the facility.</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>PA Low</p>	<p>Partial Provisional: Highview Rest Home 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 were securely stored. All chemicals were clearly labelled. Protective personal equipment was available in the sluices and laundry. Internal audits around laundry and cleaning have been completed in 2021 with 100% outcome. The laundry area is located outside behind the building and not accessible to residents, with two commercial washing machines and two commercial dryers. The area between the laundry and main building is covered but not fully enclosed to the elements. Currently all linen and personal laundry is laundered on site by the cleaning staff and healthcare assistants. In the past, due to the small design of the room, laundry was outsourced. While there is identified dirty to clean flow in the small laundry, there is no specific area for the storage and folding of clean laundry and advised this is transferred into the resident dining/lounge area for folding. There is colour coded linen bags and all linen and personal clothing items are sorted prior to washing. There are no specific handwashing basins in the laundry, but hand sanitiser is available.</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>PA Low</p>	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence, or other emergencies. Civil defence supplies (four boxes), adequate food and water including ceiling tanks, and a gas barbeque for alternative cooking are available. In the event of a power cut, there is emergency lighting in place.</p> <p>Six monthly fire evacuations are held. Fire safety training was last completed with staff March 2021. There is an approved fire evacuation plan. There have been no</p>

		<p>building changes since the previous audit that would require a new fire evacuation plan. There is a first aider on duty at all times and further staff have been booked for training in July 2021. Residents' rooms and communal areas have call bells. The operations manager advised that a new call bell system is to be installed which includes call bell pendants that hospital residents will wear. Currently there is no separate emergency call bell or sound. The upstairs lounge area does not have a call bell. The two double rooms have two call bells installed and this is an improvement on previous audit.</p> <p>Security policies and procedures are documented and implemented by staff. There are cameras installed throughout the facility. There is security lighting at night and access to the building is by call bell and intercom.</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 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 natural light. Smoking is only allowed outside in designated areas.</p>
<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	<p>The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. While the responsibility of infection control is clearly defined, this is not being fully implemented (link 3.5.7). The clinical manager is the designated infection control coordinator. 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. There is a pandemic outbreak plan and Covid STCP template. A Covid preparedness review was recently completed by the SDHB Infection control service. A few corrective actions were identified, and these are being actioned by the service (link 1.4.1.1).</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</p>	PA Moderate	<p>Infection surveillance is an integral part of the infection control programme and is appropriate to the size and complexity of Highview Rest Home. Monthly infection data is collected for all infections; however these are based on antibiotic prescribing rather than signs and symptoms of infections. Monitoring is the responsibility of the</p>

programme.		infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. How surveillance data is shared with staff is not apparent (link 1.2.3.6). Infection control meetings have been limited. Short-term care plans were in place for current infections.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There are currently no residents with restraint and seven residents with an enabler (bedrails). The clinical manager is the designated restraint coordinator.</p> <p>Two enabler files were reviewed. An assessment for the use of the enabler had been completed and evidence was sighted of voluntary consent by the resident for its use. The enabler was linked to the resident's care plan.</p> <p>Training around restraint/enablers and challenging behaviours was last completed August 2019 (link 1.2.7.5).</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service has documented evaluation of restraint every three months. There are currently no residents with restraint and seven residents with enablers (bedrails). While restraint evaluations could not be reviewed, two files reviewed where the residents had bedrails as enablers had been evaluated as per policy. This is an improvement on the previous audit.</p>

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 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	Resident and family meetings have been held in 2020, but not regularly in 2021. Eleven of eighteen incident forms reviewed identified family were informed. Family interviewed stated they were informed about concerns and adverse events.	Seven of eighteen incident forms reviewed (May and June) did not identify that family were informed following the incident.	<p>Ensure incident forms identify that family are informed.</p> <p>90 days</p>
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	PA Low	The service has a generic continued improvement policy, quality indicators, mission, philosophy statement, and generic goals/objectives. There are no specific short term quality goals identified for Highview.	The quality plan is generic and there is no specific short and long-term goals identified for Highview.	<p>Ensure the quality plan is reviewed to include short and long-term goals that are reviewed regularly and evaluated.</p> <p>90 days</p>

<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	<p>PA Moderate</p>	<p>The service has developed a 2021 meeting schedule; however meetings have not routinely been completed. While there is a meeting template available to assist with covering all key areas including quality data, this template has not been utilised in 2021.</p> <p>There have been two staff meetings documented in 2021 (YTD). There is no current established quality meeting or committee responsible for implementing the quality programme. The following committees have only met once in 2021 (YTD), infection control meetings, clinical focussed meeting, Health & safety meeting, and resident meetings.</p>	<p>(i) Meetings have not routinely been completed in 2021 and where they have been completed there is no clear structure. (ii) There is no current established quality meeting or committee responsible for implementing the quality programme.</p>	<p>(i) Ensure meetings are completed regularly including clinical focussed meetings. Ensure terms of references are determined for each committee and a meeting structure is used to evidence key quality data and follow-up of any actions required. (ii) Ensure the committee responsible of the quality programme is established.</p> <p>60 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Moderate</p>	<p>Quality data is regularly collected with trends in data identified by the clinical manager. However, it is unclear how this data is shared with staff to identify opportunities for improvement. The service does not complete any benchmarking.</p>	<p>There was no documented evidence that quality data (including complaints, adverse events, infection surveillance and internal audit results) have been shared at meetings.</p>	<p>Ensure quality data and trends are shared at meetings and opportunities for improvement are established as a result of the trends identified.</p> <p>60 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard</p>	<p>PA Moderate</p>	<p>There is a process to identify corrective actions through internal audits and quality data analysis. However corrective actions have not always been documented, or</p>	<p>(i) The two internal audits completed in 2021 that had corrective actions documented did not identify whether the corrective actions were implemented or</p>	<p>(i)-(ii) Ensure corrective actions are identified, documented, implemented, and evaluated for effectiveness.</p>

or requirements is developed and implemented.		evidence implementation and evaluation.	evaluated for effectiveness. (ii) Corrective actions are not routinely documented through meeting minutes and as a result of analysis of quality data.	60 days
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Moderate	Eighteen incident forms reviewed (May/June 2021) demonstrated that an investigation occurred following each incident. However, incident forms were not always fully completed or opportunities for improvement identified and actioned.	Eight of eighteen incident forms reviewed were not all fully completed. This included two medication errors where the actions completed post incident were not fully completed or clear. Opportunities for improvement were not always identified on the incident form and/or followed up.	<p>Ensure incident forms are fully completed.</p> <p>60 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	Discussions with healthcare assistants and management identified that there has been a high turnover of staff. It has been difficult to keep RNs as they move to employment at the DHB. Management have been interviewing and employing more staff to ensure there is cover for sick leave etc. While no transition plan has been documented around the staffing requirements for the increase in hospital beds, discussions confirmed the need for a further two registered nurses and four healthcare assistants.	Partial Provisional: The service has not developed a transition plan that identifies how many further staff they would need to employ for the potential increase in hospital residents. They are currently stretched with staff and with the increase in hospital beds it was identified that more staff including casuals would need to be appointed. However, discussions with the manager confirmed they are currently advertising and interviewing for more staff. They are planning to employ a further two registered nurses and four healthcare assistants.	<p>Ensure further staff are employed for the increase in hospital residents to safely cover the roster and leave.</p> <p>Prior to occupancy days</p>

<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 Moderate</p>	<p>The service has implemented Care training online for staff. However, this isn't monitored and therefore uptake of this training has been limited by staff. In 2020/2021 YTD the following training sessions have been provided; hand hygiene, fire & H&S, infection control/Covid, manual handling/falls, documentation, and medications. Numbers of staff that have attended is low. Training records reviewed by healthcare assistants and registered nurses identified limited education completed by staff in the last year. There is a 2021 education plan. Following the draft report, the manager has stated that the on-line care training programme which is available to all staff, some of the staff have completed segments. Hoist training has been attended to.</p>	<p>(i) An education and training plan for staff is not being fully implemented or monitored. Key education sessions have not been provided in the last 2 years which include (but not limited to); pain management, pressure injury prevention and management, challenging behaviours, dementia, continence management, restraint, and key training around policies and procedures including clinical procedures. (ii) Hoist use verification is completed by staff at orientation, however there were incomplete records to identify all support staff have current competencies.</p>	<p>(i) Ensure a training programme is implemented. Ensure all mandatory subjects are identified and staff attending sessions is monitored and followed up. (ii) Ensure all hoist use competencies are up to date.</p> <p>90 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>With an RN shortage in the area the service continues to have issues employing more RNs. There is 24/7 RNs rostered which is an improvement on previous audit. Interviews with three healthcare assistants all stated that there has been a high turnover of staff and there have been times when they have been working short staff, and double shifts to fill in the gaps. Advised by management that this has been</p>	<p>Interviews with three healthcare assistants all stated that there has been a high turnover of staff and there have been times when they have been working short staff, and double shifts to fill in the gaps. Meeting minutes and a recent 2021 complaint reflected these concerns. Advised by management that this has been addressed. How the service determines staffing in relation to</p>	<p>Ensure adequate staffing is available to cover both sick leave and annual leave. Ensure staffing is monitored in relation to acuity levels on a daily basis.</p> <p>30 days</p>

		addressed. Since the draft report the manager has stated that healthcare assistant staffing now only comes from Skillsec. The industry as a whole has current difficulties around RN's and healthcare assistance work force. Skillsec have proven to have reliable trainees.	acuity levels is not apparent.	
Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	Care plans and progress notes are paper based. All had been signed and dated by the writer which included designation. However, hand writing in many places of the care plan were difficult to read.	Hand writing in many places of the care plan were difficult to read. Interventions had been scribbled out in places, rather than a line through it and signed and dated as now obsolete.	Ensure the care plan includes clearly documented interventions. Ensure obsolete interventions are lined through and signed and dated. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Medications are stored in locked medication trolleys which are stored in the dining room on both floors. There is no separate medication/treatment room and very little bench space. There is a cupboard in the nurse's office on the ground floor that stores impress stock. This cupboard has a broken lock and was not secure. Robotic packs are also kept in a locked cupboard in the nurse's office.	Partial Provisional & Surveillance: There is no separate medication/treatment room and very little bench space and therefore the area is not ideal for managing medication for an increase in hospital/medical level residents. The impress stock cupboard had a broken lock and as a result was not secure. This was addressed immediately following the onsite audit.	Ensure there is a separate medication treatment room for the management of medications for all hospital residents. Ensure this is in place within one month and prior to occupancy of further hospital residents. Prior to occupancy days
Criterion 1.3.13.1 Food, fluid, and nutritional	PA Low	There are residents on puree diets. There was no evidence of	Partial Provisional & Surveillance: (i) The small satellite kitchen on	(i) Ensure food is covered and dated. (ii) Ensure the

<p>needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>		<p>nutritional guidelines for residents on special diets. Residents were complimentary of the food services. There is a satellite kitchenette on level one adjacent to the dining room where meals are served to residents. Meals are delivered to the upstairs servery on trolleys. Food temperatures are taken before meals are taken upstairs. Food in the kitchen fridge was covered and dated but not in the upstairs kitchenette fridge. The design of the dining room and how meals are kept warm will need to be considered for the introduction of hospital residents upstairs.</p>	<p>level one had food in the fridge not dated and covered. (ii) Food is currently trayed in the kitchen and covered and transported to the level one satellite kitchen to be passed out to residents. (iii) There are long tables in the upstairs dining room which would not allow much space for hospital residents and mobility equipment. Advised these are to be replaced by round tables.</p>	<p>temperatures of pre-trayed meals is maintained for residents that require feeding. (iii) Ensure there is sufficient space in the dining room for hospital residents and mobility equipment.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>There are currently two interRAI trained RNs. The sample of files were increased to review timeframes around interRAI and care planning. Five of eight files reviewed identified the initial interRAI had not been completed within 21 days. Five files had the long-term care plan completed prior to the interRAI. Initial assessments and risk assessments are completed at six-month intervals and when there is a change in resident condition. Long-term care plans had been evaluated within 6 months, but one care plan had been evaluated prior to the interRAI reassessment.</p>	<p>Five of eight long-term resident files reviewed did not have interRAI assessments completed within 21 days of admission or before the long-term care plan. One resident's file did not have interRAI reassessments completed six-monthly.</p>	<p>Ensure interRAI assessments are completed within 21 days of admission and prior to the long-term care plan.</p> <p>90 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Wound management policies and procedures are in place. A wound register is maintained. Wound documentation was up to date and this is an improvement on the previous audit. The service utilises a care plan template which has limited space to fully personalise the resident care plan especially for those residents with comorbidities and increased support needs. Not all care plans reviewed identified interventions to support all assessed needs.</p>	<p>The care plan template used does not allow for fully personalising the resident care plan. Three of five files reviewed lacks interventions to support current assessed needs. (i) One hospital resident had no clear interventions around continence management, the care plan contradicted whether the resident had a catheter or not. In the nutrition section of the care plan interventions refer to daily BSI monitoring, but the diabetic action plan refers to QID (noting the staff were completing QID). This resident also had a generic pressure injury care plan that was not specific to this resident. Specific pressure injury interventions were documented under the evaluation of the care plan rather than in the care plan. (iii) One hospital resident care plan was not updated to reflect current pressure injuries. The overall interventions including mobility were not up to date and reflective of all care required. The same resident's catheter change record did not reflect the catheter had been changed as per instructions. (iv) One hospital resident did not have personalised interventions to support their assessed needs.</p>	<p>(i)-(iv) Ensure care plan interventions are personalised and up to date to reflect current assessed needs.</p> <p>60 days</p>
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<p>Criterion 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.</p>	<p>PA Low</p>	<p>There is a sluice behind a cupboard on level one. This was out of order at the audit but fixed following the audit and is now functioning. There is a sluice on the ground floor. It was noted that a number of commodes are used in resident rooms at night. Neither sluices have a sanitiser and with the increased use of commodes and hospital residents. The ARC preparedness review completed by the SDHB IC specialist also identified a partial rating around not having a sanitiser. Staff interviewed indicated a clear understanding of processes and protocols.</p>	<p>Partial Provisional: There is a sluice behind a cupboard on level one. This was out of order at the audit but fixed following the audit and is now functioning. There is a sluice on the ground floor. It was noted that a number of commodes are used in resident rooms at night. Neither sluices have a sanitiser and with the increased use of commodes and hospital residents.</p>	<p>Consider a sanitiser/macerator as part of the long-term plan</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>Medical equipment and electrical appliances have been tested and tagged and calibrated. Essential contractors are available 24-hours. The maintenance person is new to the role and works 4 hours a day. While reactive maintenance is completed there is no current documented preventative maintenance plan. Fire equipment is checked by an external provider. The carpet in the lounge area has rolled and advised that this is to be stretched next week. Since the draft report the manager has stated that the preventative maintenance plan has been implemented and the new maintenance person has</p>	<p>Surveillance & Partial Provisional: (i) There is no documented preventative maintenance plan. (ii) The carpet in the lounge area has rolled and advised that this is to be stretched next week.</p>	<p>(i)-(ii) Ensure there is a documented preventative maintenance plan that is implemented.</p> <p>30 days</p>

		been trained to it.		
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	<p>Healthcare assistants interviewed stated there have been issues with equipment. There is one tilting shower chair that has been broken and awaiting parts. This breaks frequently and was broken for a month which made it difficult to shower certain hospital residents that required the tilting chair. Following this onsite audit the part arrived and the shower chair has been fixed (8 July 2021). The recent medical dental equipment checks/audit failed on the hoist slings. This was addressed by management and a new toileting sling was purchased. There are currently two sling hoists and one standing hoist. Interviews with the operations manager (director) confirmed with the increase in hospital beds there is plans to purchase 10 lazy boys with wheels, two sling hoists, new hospital beds and a further tilting shower chair. Other equipment such as pressure relieving mattresses are in storage and available to access across their organisation.</p>	<p>Partial Provisional: There is one tilting shower chair that has been broken and awaiting parts. This breaks frequently and was broken for a month which made it difficult to shower certain hospital residents that required the tilting chair. Following this onsite audit the part arrived and the shower chair has been fixed (8 July 2021). The recent medical dental equipment checks/audit failed on the hoist slings. This was addressed by management and a new toileting sling was purchased. An equipment list is in place and will be purchased with the increase in hospital residents.</p>	<p>Ensure there is appropriate working equipment in place for the increase in hospital residents.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.4.1</p> <p>Adequate space is provided to allow the consumer and</p>	PA Low	<p>There are three further rooms on the ground floor (109, 111, 112) that were reviewed as part of this</p>	<p>Partial Provisional: Rooms 202-207 and 209-211 on level one and rooms 109, 111, 112 on the ground</p>	<p>For the Rooms 202-207 and 209-211 on level one and rooms 109, 111, 112 on the ground floor to</p>

<p>service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.</p>		<p>audit but were verified as not suitable for hospital level due to the small size of these rooms and furnishings taking up too much space. On level one, rooms 215, 216 and 219 and the double-room (214) were verified at this audit as large enough for hospital (dual-purpose) level care. Rooms 202-207, 209-211 were reviewed at this audit but assessed as not suitable due to the small size and current furnishings taking up too much space. The service would have to determine how best to provide storage space as well as furniture to make the room suitable for hospital level care.</p>	<p>floor were reviewed at this audit but assessed as not suitable for hospital level due to the small size and current furnishings taking up too much space. The service would have to determine how best to provide storage space as well as furniture such as a lazy boy to ensure suitable space in the room for safely manoeuvring mobility equipment, staff, and resident.</p>	<p>be approved as dual-purpose, the rooms would need to provide adequate storage space in these rooms as well as furniture and space for staff/resident and mobility equipment prior to it being approved as suitable for hospital level care. Following these changes, rooms would require approval as suitable by the DHB.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>	<p>PA Low</p>	<p>Currently all linen and personal laundry is laundered on site by the cleaning staff and healthcare assistants. In the past, due to the small design of the room, laundry was outsourced. While there is identified dirty to clean flow in the small laundry, there is no specific area for the storage and folding of clean laundry and advised this is transferred into the resident dining/lounge area for folding. There is colour coded linen bags and all linen and personal clothing items are sorted prior to washing. There are no specific handwashing basins in the laundry, but hand sanitiser is available.</p>	<p>Partial Provisional: The current size of the laundry is not suited to an increase in dirty linen. There are no specific handwashing basins in the laundry, but hand sanitiser is available. While there is identified dirty to clean flow in the small laundry, there is no specific area for the storage and folding of clean laundry and advised this is transferred into the resident dining/lounge area for folding.</p>	<p>Ensure the process around completing laundry on site is reviewed.</p> <p>Prior to occupancy days</p>

<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Low	<p>The service is in the process of updating their fire evacuation procedure to consider level one providing hospital level care. This is yet to be finalised and reviewed and approved by the fire service. Since the draft report the manager has advised that the updated fire evacuation procedure is now with the fire service in draft.</p>	<p>Partial Provisional: The service is in the process of updating their fire evacuation procedure for review by the fire service.</p>	<p>Ensure the fire evacuation procedure is updated and approved by the fire service.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	PA Low	<p>The operations manager advised that a new call bell system is to be installed which includes call bell pendants that hospital residents will wear. Currently there is no separate emergency call bell or sound. The upstairs lounge area does not have a call bell.</p>	<p>Partial Provisional: Currently there is no separate emergency call bell or sound. The upstairs lounge area does not have a call bell.</p>	<p>Ensure a call bell system is available in all areas and a process around recognising emergencies is in place.</p> <p>Prior to occupancy days</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	PA Moderate	<p>Monthly infection data is collected for all infections and this includes an analysis; however, surveillance data is based on antibiotic prescribing rather than signs and symptoms of infections. 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. How surveillance data is shared with staff is not apparent. Overall</p>	<p>(i) Monthly infection data is collected for all infections; however, these are based on antibiotic prescribing rather than signs and symptoms of infections. (ii) How surveillance data and specific recommendations is shared with staff is not apparent. (iii) There is a lack of infection control meetings or a committee responsible for infection control.</p>	<p>(i) Ensure infection surveillance data meets definitions. (ii) Ensure surveillance analysis, trends and specific recommendations is shared with staff. (iii) Ensure IP & C is overseen by an IC team or assigned committee.</p> <p>90 days</p>

		responsibility for infection control is not clear.		
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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.