

Elsdon Enterprises Limited - Highview Home & Hospital

Introduction

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

The audit has been conducted by 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: 22 February 2022 End date: 22 February 2022
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:	41

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

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 41 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.

The facility manager has been in the role since 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 10 of the 22 previous partial provisional/surveillance audit shortfalls around the quality plan, meetings, internal audits, corrective actions, incident forms, staffing, documentation, interRAI timeframes, maintenance and infection surveillance.

Further improvements continue to be required around open disclosure, informing staff of quality outcomes, transition plan for staffing for more hospital level residents, education, implementation of care, medication storage, food service, equipment, linen and spatial requirements for additional hospital level care residents, fire evacuation plan, and call bells.

This surveillance audit identified further shortfalls around orientation of new staff.

Consumer rights

<p>Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents and families are made aware of the complaints process. Verbal and written complaints are recorded in a complaint register.

Organisational management

<p>Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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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 policies are available, and employees have a staff appraisal completed on an annual basis.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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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

<p>Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The building holds a current warrant of fitness, which expires on 20 December 2022. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and tagged and calibrated. There is a lift between floors that is large enough for a tilted ambulance stretcher. 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

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents on the restraint register for restraint and five residents on the register that were using an enabler (bedrails). The clinical manager is the designated restraint coordinator.

Infection prevention and control

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

Standards applicable to this service fully attained.

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	5	5	0	0
Criteria	0	37	0	6	7	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, families and ten staff (three healthcare assistants (HCAs) (two on the AM shift and one on the PM shift), three RNs, two kitchen staff, one diversional therapist, one maintenance) demonstrated their understanding of the complaints process. Residents and family 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 meeting minutes although not all staff are provided with this information (link 1.2.3.6).</p> <p>Verbal and written complaints are recorded in a complaint register. There were three complaints logged in the register for 2021 and none in 2022 (year to date). All complaints reflected evidence of being resolved.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	PA Moderate	<p>Four (rest home level) residents interviewed 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 and frank open disclosure occurs. Interviews with the RN staff (one clinical manager, two registered nursing [RN] staff) confirmed that they are aware that family are to be notified following an adverse event or a change in the resident's condition. Fifteen incident/accident forms reviewed from December 2021 through January 2022 identified that family notification was</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>not consistently being documented. This previous finding remains.</p> <p>Three families interviewed (two rest home and one hospital/young person with a disability YPD) 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 (including one room with two beds) and 19 dual-purpose beds. At the time of the audit the facility was full of 41 residents. Nineteen beds are approved on the ground level as suitable for dual-purpose use.</p> <p>At the time of the audit, there were 19 hospital residents including one resident on a YPD contract, and 22 rest home residents including one resident on respite (ACC), and one resident on an LTS-CHC (long-term support – chronic health conditions) contract. The remaining residents were under the age-related residential care (ARRC) agreement.</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 Directors (operations manager) who provides oversight to the facility and meets regularly with the management team.</p> <p>The service has purchased their policies from an external consultant. Included in the policies are quality indicators, mission, philosophy statement, and both generic and specific goals/objectives. The business plan is reviewed with the business owners and updated on an annual basis.</p> <p>The manager has undertaken training relating to her management role and has completed a minimum of eight hours of professional development over the past year relating to her management role at Highview Home and Hospital.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>PA Moderate</p>	<p>A quality and risk management programme are documented. In addition to the generic goals/objectives, specific goals were documented and reviewed in 2021. New and specific goals have also been documented for 2022. This is an improvement from the previous audit.</p> <p>A system of document control is in place. Policies are scheduled to be reviewed two yearly and this is being monitored by the facility manager.</p> <p>The monthly collating and analysis of quality and risk data includes monitoring accidents and incidents and infection</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>rates. Trends in falls data are documented with improvements noted to address those residents who are prone to falls or have fallen. This is an improvement from the previous audit.</p> <p>Quality meetings and staff meetings follow a template which covers complaints received (if any), incidents/accident, infection control, internal audits completed and corrective actions (if any), pressure injuries, training, health and safety, restraint, policies and procedures and medication. Quality meetings take place two-monthly. Staff meetings, scheduled two-monthly, indicate that quality data (including complaints, adverse events, infection surveillance and internal audit results) are discussed but attendance at these meetings is low and staff interviews indicated that meeting minutes are not regularly shared with staff. This previous finding remains.</p> <p>There is an internal audit schedule and internal audits regularly monitor compliance. Internal audits have been completed in 2021 as per schedule. Where the corrective actions identify areas for improvements, these actions are signed off to indicate that they have been implemented and evaluated. This is an improvement from the previous audit.</p> <p>A resident satisfaction survey for 2021 was completed with fifteen respondents. Residents expressed their satisfaction with the services received and no corrective actions were identified.</p> <p>There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. Health and safety are overseen by the operations manager and facility manager. Health and safety training begins during staff induction and was last completed 16 November 2021. Health and safety are a regular agenda item in the quality and staff meetings. This is an improvement from the previous audit. There is a current hazard register which is reviewed a minimum of annually.</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</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate</p>	<p>FA</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. Fifteen incident forms reviewed (witnessed and unwitnessed falls) demonstrated that an investigation occurred following each incident. Incident forms were fully completed and included corrective actions necessary to prevent reoccurrence. This is an improvement from the previous audit. Neurological observations were completed for unwitnessed falls or if there was a suspected injury to the head.</p> <p>Discussion with the facility manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. Notifications were made for one outbreak that occurred in October 2021. No section 31 reports have been required since the last audit.</p>

their family/whānau of choice in an open manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>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 resources policies to support recruitment practices. A list of practising certificates is maintained for healthcare professionals.</p> <p>Five staff files were initially selected randomly for review (one clinical nurse manager/RN, one staff RN, one HCA, one cook, one kitchenhand). Sighted was evidence of signed employment agreements and job descriptions. Performance appraisals are completed annually for those staff who have been employed for over 12 months. Missing was evidence of reference checking. The facility manager reported that she completes reference checks for new staff but does not document this.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists. Evidence of staff completing their orientation programme were sighted in only three of five staff files with two staff files being casual staff. The sample was increased to an additional six casual staff (total eleven). None of the eight casual staff files had evidence that orientation paperwork was completed. The facility manager stated that they had been orientated but had not returned their orientation paperwork.</p> <p>There are 18 HCAs employed. Eight hold a level four qualification, three have level three and two have a level two qualification. There is one foreign trained registered nurse working as an HCA. Healthcare assistants can access NZQA qualifications through Skill Set.</p> <p>A 2022 education schedule is in place. Staff attendance is low and mandatory topics other than fire training and health and safety have not been identified. Staff have completed a manual handling training competency. This is an improvement from the previous audit. Select HCA staff and all RNs complete an annual medication competency. Numbers of staff that attend in-service training remains low. This previous finding remains. The registered nurses are able to attend external training including sessions provided by the DHB. Syringe driver training for RNs has been completed.</p> <p>One of six RNs has completed their interRAI training (the clinical nurse manager). Two RNs were in training at the time of the audit. There is a minimum of one trained first aider on every shift.</p> <p>A transition plan to address strategies for the employment of additional RNs to staff an increase in hospital level beds has not been implemented. This previous finding remains.</p>
Standard 1.2.8: Service Provider	FA	<p>There is a documented rationale for staffing. The facility manager works full time (Monday to Friday) and is available 24/7 for any operational issues. She contracts the clinical manager if clinical issues arise afterhours.</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>There is one RN rostered for each shift. This RN is the clinical manager for the AM shift, three days a week (0700 – 1400).</p> <p>Interviews with HCAs stated staff levels had improved and that they work extra shifts to cover absences. Casual staff employed over the holidays was appreciated by the HCAs (link 1.2.7.4). Of greatest concern was the HCA working on the first level on their own (AM and PM shift HCA interviewed) without access to an emergency call system (link 1.4.7.5). Relatives interviewed stated staffing levels were sufficient.</p> <p>Ground Floor (8 rest home, 19 hospital)</p> <p>AM shift: Clinical Manager 0700 - 1400 Monday – Friday, working as an RN staff Tuesday - Thursday</p> <p>One staff RN 0700 – 1500 Monday, Friday, and weekends</p> <p>HCAs: Three long (0700 – 1500) and four short shifts (1700 – 2100)</p> <p>PM shift: one RN</p> <p>HCAs one long and three short shifts (1700 – 2100, 1500 – 2200, 1600 – 2000)</p> <p>Night shift: RN 2300 – 0700</p> <p>HCA one long shift</p> <p>Level one: (14 rest home)</p> <p>HCA one long and one short (0700 – 0900) PM Shift: one long shift, Night: one long shift</p> <p>Staffing levels meet contractual requirements with core staff and casual staff covering absences. This previous area identified for improvement is now being met by the service.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when</p>	<p>FA</p>	<p>Care plans and progress notes are paper-based. All had been signed and dated by the writer which included designation. Handwriting in the care plans was legible. This previous finding is now being met.</p>

required.		
<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. Temperatures of the medication fridge, staffroom fridge and rooms where medications are stored are maintained within the acceptable ranges. The controlled drugs are checked weekly by 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. Competencies include insulin, warfarin, and syringe drivers. Appropriate practice was demonstrated on the witnessed medication rounds.</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>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, and this was locked. Robotic packs are also kept in a locked cupboard in the nurse's office. The previous audit finding remains unmet.</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>	PA Low	<p>There is a small centrally located kitchen. All meals are cooked on site for the facility. A food control plan is in place and expires 31 March 2023.</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.</p> <p>Fridge temperatures are monitored and recorded daily in the kitchen. Food in both the upstairs kitchenette and the downstairs kitchen was covered and dated. Cleaning schedules are maintained and signed by staff. There is a</p>

		<p>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 complimentary of the food service.</p>
<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>Care plans reviewed identified interventions to support all assessed needs including activities of daily living, skin and pressure care, mobility and transfers, nutrition, continence, communication, pain, sleep, orientation, behaviour, identity, and any specific medical needs such as diabetes management. The service has addressed this aspect of the previous finding.</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, and challenging behaviours. Monitoring records for turning charts and restraint monitoring were incomplete.</p> <p>Wound management policies and procedures are in place and a wound register is maintained. 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 six wounds: four venous leg ulcers, and two skin tears. District nursing service were providing wound care for two chronic leg ulcers and a wound specialist had been involved with wound care for these wounds. There were no pressure injuries on the day of audit.</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 18 years and qualified as a diversional therapist in 2016. A weekly programme is developed in consultation with residents 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 when Covid restriction allows. 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/whanau/EPOA as appropriate, is involved in the development of the</p>

<p>service.</p>		<p>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 were satisfied with the activities provided.</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. 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 participation in care plan evaluations and this was evidenced in the files reviewed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during</p>	<p>PA Low</p>	<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 on the ground floor and a sluice on the first floor. The finding from the previous partial provisional audit remains.</p>

service delivery.		
<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 2022. 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 works 4 hours a day for two days per week. Reactive maintenance is completed, and there is a documented preventative maintenance plan for 2022. This is an improvement on the previous audit. Fire equipment is checked by an external provider. The carpet in the lounge area has been replaced, and floor lino has been replaced in the hair salon area and the downstairs dining room. The carpet in the entrance hall and Maitland wing including a walk-through has been replaced and this is an improvement on previous audit.</p> <p>Residents were observed to mobilise safely within the facilities. There are sufficient seating areas throughout the facilities. 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. Slings and hoists have been checked and resident equipment is available. Advised that additional hospital grade beds are available as needed from storage when additional hospital level residents are ready to be admitted. The service has met this aspect of the previous audit finding.</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>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>The original Highview rest home is an old two-story villa. There are a number of large rooms and much smaller rooms. The finding regarding rooms 202-207, and 209-211 reviewed at previous audit and deemed unsuitable for hospital level care residents, remains.</p> <p>There are handrails around hallways and up raised ramps. Residents and relatives are encouraged to personalise their rooms as viewed on the day of audit.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe</p>	PA Low	<p>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. 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</p>

<p>and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>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 Moderate</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, 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 in March 2021. There is an approved fire evacuation plan for the current layout and resident cohorts. There have been no 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.</p> <p>Residents' rooms and communal areas have call bells. Currently there is no separate emergency call bell or sound. The upstairs lounge area does not have a call bell. This previous finding remains.</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>The previous audit finding around revised fire evacuation plan that identifies additional hospital level beds on the first level had not been completed. This previous finding remains.</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</p>	<p>FA</p>	<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. The service has made modifications to the infection reporting form. Monitoring is the responsibility of the clinical manager who is 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 (link 1.2.3.6). Infection control meetings are part of the quality meeting and is a standing agenda item. Short-term care plans were in place for current infections.</p> <p>Visitors are asked not to visit if they are unwell. Hand sanitisers were appropriately placed throughout the facility. The service has clearly defined Pandemic plans for COVID-19 alert levels and has procured sufficient supplies of PPE. COVID isolation kits have been put together in readiness, and education and training for staff has been provided. Contact-less visiting is currently permitted under strict protocols which allows residents to see and</p>

control programme.		<p>converse with visitors through a see-through screen divider. COVID vaccinations have been provided for staff and residents.</p> <p>A Norovirus outbreak in October 2021 was managed with appropriate notification and infection control protocols implemented.</p>
<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 were no residents with restraint and five 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 consent by the resident for its use. The enabler was linked to the resident's care plan and is reviewed three-monthly. Monitoring while the bedrails are in place was missing on the PM shifts (link 1.3.6.1).</p> <p>A staff competency around restraint/enablers has been completed. Staff training on challenging behaviours is due (link 1.2.7.5).</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)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Moderate	Only five of fifteen incident forms reviewed identified family were informed. Family interviewed stated they were informed about concerns and adverse events.	Ten of fifteen incident forms reviewed (December 2021 – January 2022) did not identify that family were informed following the incident.	Ensure incident forms identify that family are informed. 90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate,	PA Moderate	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. The service does not complete any benchmarking.	Attendance at staff meetings is very low. There was no documented evidence that staff meeting minutes, which include quality data (e.g., complaints, adverse events, infection surveillance and internal audit results) have been shared with staff who were unable to attend the meetings. Interviews with staff confirmed that they have	Ensure quality data is shared with staff. 60 days

consumers.			not been made aware of the documented quality results.	
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Moderate	<p>Evidence of reference checking new staff is not being documented.</p> <p>Discussions with healthcare assistants and management identified that there has been a high turnover of staff, in particular RN staff. One RN is leaving later in the month (February 2022). 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 additional registered nurses and healthcare assistants.</p>	<p>(i) Evidence of reference checking was missing in all staff files reviewed, including casual staff (three permanent staff and eight casual staff); (ii) The service has not developed a transition plan to identify how many additional staff they would need to employ for the potential increase in number of hospital residents. They are currently stretched with staff and with the increase in hospital beds it was identified that more staff would need to be appointed.</p>	<p>(i) Ensure there is documented evidence to confirm that reference checking is documented as part of the employment process; (ii) Ensure that 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 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Moderate	<p>Three permanent staff files reviewed reflected evidence of completed orientation programmes. The care home relies on casual staff to help with cover during staff absences, in particular over the 2021/2022 holiday period. There was a lack of documented evidence to indicate that any casual staff had completed their orientation. The facility manager stated that they were orientated but had not submitted their completed orientation paperwork.</p>	<p>Evidence of casual staff completing an orientation was missing in all eight casual staff files reviewed.</p>	<p>Ensure all staff including casual staff complete an orientation and that this is documented.</p> <p>60 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing</p>	PA Moderate	<p>The education and training plan for staff is not fully implemented. Attendance is very low at in-services. Healthcare assistant interviews confirmed that they are too busy when at work to attend and do not wish to come in on their days off (which are unpaid unless</p>	<p>An education and training plan for staff is not being fully implemented. Health and safety and fire safety are the only mandatory topics. Attendance</p>	<p>Ensure a training programme is implemented. Ensure all mandatory subjects are identified and reflect high</p>

education for service providers to provide safe and effective services to consumers.		mandatory).	was very low in 2021/2022 (YTD). The following topics were offered with numbers of staff attending (in parentheses); health and safety (24), fire safety (23), diabetes update (8), infection prevention and control (6), observing and responding to changes (5), chemical handling (10), personal cares (6), elder abuse (9) and continence management (10).	levels of staff attendance. 60 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.	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.	Ensure there is appropriate space and storage for the safe management of medications for all hospital residents. Ensure this is in place prior to occupancy of further hospital residents. Prior to occupancy days
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are	PA Low	There are residents on puree 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.	(i) There are long tables in the upstairs dining room which would not allow much space for hospital residents and mobility	Ensure there is sufficient space in the dining room for hospital residents and mobility equipment prior to

provided in line with recognised nutritional guidelines appropriate to the consumer group.		Meals are delivered to the upstairs servery on trolleys. Food temperatures are taken and recorded before meals are taken upstairs. Food in fridges was covered and dated. The design of the dining room and how meals are kept warm will need to be considered for the introduction of hospital residents upstairs. This remains a finding from previous audit.	equipment. Advised these are to be replaced by round tables, however, this has not yet happened.	occupancy of hospital level residents on the first floor. Prior to occupancy days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Monitoring records were in place for weight management, behaviour charts, pressure area care including repositioning charts, and restraint monitoring charts. Not all charts were fully completed. Restraint monitoring and repositioning charts were completed for two hospital level residents during the night shift hours.	Restraint monitoring and repositioning charts were not completed for two residents between early evening and when the night staff commence. Afternoon shift staff had not documented that bedrails had been monitored for safety and risk, and repositioning of the residents had not been documented for the whole time the residents were in bed	Ensure that monitoring and recording is completed for all residents when restraint is in place and for all residents who require repositioning and turning. 60 days
Criterion 1.4.1.1 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	PA Low	There is a sluice behind a cupboard on level one and there is a sluice on the ground floor. It was noted that a number of commodes are used in resident rooms at night. Neither sluice rooms have a sanitiser which has been recommended with the proposed 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.	There is no sanitiser available in the facility as identified by an IC specialist.	For the expected increase of hospital level resident numbers and increase in commodes, the sanitiser identified as required as part of the long-term plan should be purchased. Prior to occupancy days

authority requirements.				
<p>Criterion 1.4.4.1</p> <p>Adequate space is provided to allow the consumer and 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>	PA Low	<p>Rooms 109, 111, 112 and 202-207, 209-211 were reviewed at the previous audit but assessed as not suitable due to the small size and current furnishings taking up too much space. Following the previous audit, the service has modified the layout of one room upstairs in order to increase the amount of usable space therein. The facility manager advised that in this corner room, they have removed a large dresser and replaced it with a smaller set of drawers and removed a wardrobe. On inspection, the resident's clothes are now hung on hooks on a wall behind the door. There still remains an issue with workable space around the bed should it need to be pulled out from the wall. The current bed in the room is a mattress and base and not a hospital grade bed.</p>	<p>Reconfiguration and layout of rooms identified as possible hospital level rooms, remains an issue due to insufficient storage space for resident's clothes and belongings, and insufficient room to manoeuvre bed, and equipment required for care staff and resident.</p>	<p>For the Rooms 202-207 and 209-211 on level one and rooms 109, 111, 112 on the ground floor to 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</p> <p>Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>	PA Low	<p>All linen and personal laundry is currently 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. Advised by the facility manager that linen services would be outsourced, but this has not been arranged including minimum</p>	<p>The current size of the laundry remains unsuitable for 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. Clean laundry continues to be transferred into the resident dining/lounge area for folding.</p>	<p>Ensure the process around completing laundry on site is reviewed and an action plan implemented to ensure there is adequate hand hygiene available, clean areas for storage and folding of clean laundry and the laundry is suitable for an increase in dirty laundry.</p> <p>Prior to occupancy days</p>

		requirements of towels and sheets for an increase in hospital level residents.		
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Low	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.	The service is in the process of updating their fire evacuation procedure for review by the fire service.	<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 Moderate	A new call bell system is a quality goal for 2022. It has not yet been installed. There was no evidence of call bell pendants being used by residents. Currently there is no separate emergency call bell or sound. In addition, the upstairs lounge area does not have a call bell.	There is no separate emergency call bell or sound. Two HCAs interviewed who work on the first level (AM and PM shifts) stated that when working (alone) on the first level, they are unable to contact downstairs staff to indicate there is an emergency unless they have their phone with them	<p>Ensure a call bell system is available in all areas and a process around recognising emergencies is in place</p> <p>60 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.