Taslin NZ Limited - Hillcrest Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Taslin NZ Limited
Premises audited:	Hillcrest Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 August 2019 End date: 9 August 2019

Proposed changes to current services (if any): The provisional audit was completed to assess the suitability and preparedness of the prospective new owners. The intended date of purchase is for the 25 September 2019.

Total beds occupied across all premises included in the audit on the first day of the audit: 11

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

Hillcrest Rest Home provides rest home level care for up to 20 residents. On the day of the audit there were 11 residents.

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

The home is privately owned and operated under the current owner/manager for the past five years. The owner/manager is supported by a registered nurse with experience in aged care. Residents, family and the general practitioner interviewed were complimentary of the care and service received at Hillcrest Rest Home.

This provisional audit included an interview with the prospective owner. The prospective owner currently owns another aged care facility and has policies and processes in place around the understanding of consumer rights. The prospective owner stated that

their governance and quality plan, and policies and procedures will be reviewed after the sale (approximately three to six months). There were no plans at this stage to make changes to the environment.

The provisional audit identified areas for improvement around neurological observations, interRAI assessments, documented interventions and medication fridge temperatures.

Consumer rights

The staff at Hillcrest Rest Home ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussion with a family member identified that they are fully informed of changes in their family member's health status. Information about the Code and advocacy services is easily accessible to residents and families. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process. Communication with families is recorded. Complaints processes are implemented and managed in line with the Code.

Organisational management

Hillcrest Rest Home is implementing a quality and risk management system that supports the provision of clinical care. Quality management processes are reflected in the businesses plans, goals, objectives and policies. Quality data is collated and discussed at staff and quality and risk management meetings. There is a current business plan in place. Staff document incidents and accidents. There are human resources policies including recruitment, job descriptions, selection and orientation. The service has an orientation programme that provides new staff with relevant information for safe work practice. The service has an annual training schedule for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

The registered nurse is responsible for each stage of service provision. There is an admission package available prior to or on entry to the service. A registered nurse assesses and reviews each resident's needs, outcomes and goals. Care plans demonstrated service integration and included medical notes by the general practitioner and visiting allied health professionals. Medications are managed appropriately in line with accepted guidelines. Senior carers who are responsible for administration of medication complete annual education and medication competencies. An activities coordinator implements an activities programme for the residents. The programme includes community visitors, outings and activities that meet the individual and group recreational preferences for the residents. Residents' food preferences and dietary requirements are identified at admission. All meals and baking are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. Dislikes are accommodated.

Safe and appropriate environment

The building has a current warrant of fitness and emergency evacuation plan in place. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Resident bedrooms are spacious and personalised. There are sufficient communal shower/toilet facilities. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Systems are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

Restraint minimisation and safe practice

Hillcrest Rest Home has restraint minimisation and safe practice policies and procedures in place. There were no residents requiring the use of a restraint or enabler. Staff receive training in restraint minimisation and challenging behaviour management.

Infection prevention and control

The infection control management system is appropriate for the size and complexity of the service. The infection control coordinator (registered nurse) working together with the owner/manager, is responsible for coordinating and providing education and training for staff. The infection control manual outlined the scope of the programme and included a range of policies and guidelines. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff and residents are offered the annual flu vaccine. There have been no outbreaks since the last audit.

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	41	0	3	1	0	0
Criteria	0	89	0	3	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with six staff (one owner/manager, one registered nurse (RN), three caregivers and one activities coordinator) confirmed their familiarity with the Code. Seven residents and two family members interviewed confirmed the services being provided are in line with the Code. Staff completed training on the Code in July 2019. The prospective owners have over 17 years of aged care experience and own another aged care facility in Taradale. They have policies and processes in place around the understanding of consumer rights.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice	FA	The service has established policies and procedures relating to informed consent and advanced directives. All files reviewed included signed informed consent forms and advanced directive instructions. Staff

are provided with the information they need to make informed choices and give informed consent.		interviewed were aware of advanced directives, informed consent and informed consent processes. General written consents were obtained on admission. Specific consents sighted were obtained for specific procedures such as influenza vaccine. There was evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order where residents were deemed not to be competent. Discussions with residents and families identified that the service made them aware of the informed consent processes and that appropriate information had been provided to ensure residents and families were actively involved in decision making. The RN and caregivers interviewed confirmed verbal consent is obtained when delivering care. Five long-term rest home resident files were reviewed and had signed admission agreements by residents or their nominated representative.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Rights to access advocacy services and independent advocates is identified for residents. Advocacy leaflets are available in the facility foyer area. The information pack provided to residents prior to entry includes advocacy information. The information identifies who the resident can contact to access advocacy services. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members that were interviewed were aware of their access to advocacy services. Staff completed training on advocacy and privacy in July 2019.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and family members interviewed confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility.
Standard 1.1.13: Complaints Management	FA	The complaints policy and procedures have been implemented and

The right of the consumer to make a complaint is understood, respected, and upheld.		residents and their family/whānau are provided with information on admission. The residents and family members interviewed were aware of the complaints process and to whom they should direct complaints. Complaint forms are visible at the entrance of the facility. A complaints register is maintained. There have been three complaints (all in 2019) made since the last audit. The documentation for the complaints reviewed showed investigation and actions taken, and that the complainants have been informed of the outcome/result.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code and advocacy pamphlets are located at the main entrance of the service. On admission the owner/manager or RN discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and family members interviewed identified they are well informed about the Code.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, residents' privacy and dignity. House rules are signed by staff at commencement of employment. Residents and family interviewed reported that residents are able to choose to engage in activities and access community resources. There is an abuse and neglect policy in place and staff completed training on abuse and neglect in September 2018.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has guidelines for the provision of culturally safe services for Māori residents. On the day of the audit there were three residents that identified as Māori. The service has established links with local Māori community members who provides advice and guidance on cultural matters. Staff interviewed confirmed they are aware of the need to respond appropriately to maintain cultural safety.

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents and the family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. The family members reported that they feel they are consulted and kept informed and family involvement is encouraged.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service meets the individualised needs of residents with needs relating to rest home level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-service training. Monthly staff and quality and risk management meetings and annual residents' meetings are conducted. Staff interviewed stated that they feel supported by the owner/manager and RN. Residents and family members interviewed spoke positively about the care and support provided.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Residents and family members interviewed confirmed that the owner/manager, RN and staff are approachable and available. Ten incident forms reviewed identified family were notified following a resident incident. The family members interviewed confirmed they are notified of any incidents/accidents. Families are invited to attend the monthly resident meeting. The service has policies and procedures available for access to interpreter services for residents (and their

		family). If residents or family/whānau have difficulty with written or spoken English, then interpreter services are made available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Hillcrest Rest Home provides care for up to 20 rest home level residents. On the day of audit there were 11 rest home residents. There was also one boarder living in one of the two outside flats on the property. On the day of the audit, there were two resident rooms being used as a family room and the other as an office. Two residents were on mental health contracts (one resident was under the age of 65). All other residents were under the aged related residential care (ARRC) contract. Hillcrest Rest Home is owned by Muralz Limited. The owner/manager (non-clinical) has owned the business for five years and lives locally. The owner/manager is supported by a RN who has been in the role for two years. There is a documented business plan, which includes business performance targets for the period from 1 April 2019 to 31 March 2020. The owner/manager has maintained at least eight hours annually of professional development activities related to managing a rest home and has a certificate in rest home management. The prospective owner currently owns another 40-bed rest home facility in Taradale. The prospective new owner will continue current memberships with established professional bodies. The manager is intending to manage both sites and spread her time between the two. There is also a clinical nurse manager at the Taradale that can provide support. There is a documented transition plan and the current manager of Hillcrest is going to be available to support the prospective owners.
Standard 1.2.2: Service Management 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.	FA	The owner/manager reported that in the event of her temporary absence the RN fills the role with support from the care staff. The same arrangement will continue in the event of temporary absence of the prospective new owner; however, the RN and staff will have the support

		from the clinical nurse manager from the other facility in Taradale.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The quality manual and the business, quality, risk and management planning procedure describe the quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored through the monthly staff and quality meetings. Meeting minutes have been maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with caregivers confirmed their involvement in the quality programme. Monthly data is collected on complaints, accidents, incidents, infection control and is provided to staff to read and sign. Residents are surveyed annually to gather feedback on the service provided, however, there were no responses received from the satisfaction survey sent out in November 2018. A resident/relative meeting is held monthly. A quarterly newsletter is emailed to family/whānau, and an update on their family member's health status and progress is also provided. The internal audit schedule for 2019 is being completed as per schedule. Areas of non-compliance identified at audits have been actioned for improvement. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service has in place a range of policies and procedures to support service delivery that are developed by an external consultant. Staff interviewed confirmed they are made aware of new/reviewed policies. There is a health and safety and risk management system in place including policies to guide practice. Hazard identification forms are completed for any accidents or near misses and an up-to-date hazard register was in place, last reviewed 14 June 2019. Falls prevention strategies are implemented for individual residents. The prospective owner advised that their governance and quality plan, and policies and procedures will be reviewed after the sale (approximately three to six months).

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.	PA Moderate	There is an incident reporting policy that includes definitions and outlines responsibilities. Ten accident/incident forms for the month of June and July 2019 were reviewed. The accident/incident forms reviewed document timely RN review and follow-up. However neurological observations were not completed for four unwitnessed falls with a potential head injury. There is documented evidence the family had been notified of incidents/accidents. Three resident falls reviewed did not have an accident/incident form completed. Discussions with the owner/manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There has been one section 31 notification lodged since the last audit, in relation to difficulties in obtaining medical services from their local GP practice.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources policies to support recruitment practices. Five staff files (one RN, three caregivers and one activities coordinator) were reviewed. All files include documentation that reflected good employment processes. Completed orientation documentation. training and appraisals were on file. Performance appraisals were current. A current practising certificate was sighted for the RN. The RN has completed interRAI training (link 1.3.3.3). The service has an orientation programme in place to provide new staff with relevant information for safe work practice. The caregivers' complete competencies relevant to their role such as medication competencies. There is an education planner in place that covers compulsory education requirements over a two-year period. Compulsory education/training has been completed since the last audit.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented rationale for staffing the service. Staffing rosters were sighted, and staff are on duty to match needs of different shifts and needs of individual residents. The owner/manager works fulltime from Monday to Friday and the RN works for eight hours across the week. The owner/manager and RN are available on call to provide afterhours

		cover for any operational and clinical issues respectively. The owner/manager and RN are supported by two caregivers on the morning and afternoon shifts, and one caregiver on the night shift. Interviews with the residents and family members confirmed staffing overall was satisfactory. The prospective owner stated that there were not any proposed changes to the staffing levels. Staff interviews were taking place at the time of the audit.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are policies and procedures in place to guide resident admissions. Needs assessments establishing the level of care are required prior to entry to the facility. There is an information pack provided to all residents and their families on services available. Residents and or family/whānau are provided with associated information (eg, information on their rights, the Code, complaints management, advocacy, and the admission agreement). The owner/manager screens all potential residents prior to entry and records all admission enquires. Family members and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. The five long-term admission agreements reviewed align with the expectations in the aged residential care agreement and includes exclusions from the service.

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. The service would transfer residents out that require a higher level of care.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	There are policies and procedures in place for all aspects of medication management. There were no residents self-administering on the day of audit. There was one medication room in the facility that had locked access. The medication fridge temperatures were not regularly monitored and recorded. The senior caregivers who administer medications have completed their annual competency assessment. There is a signed agreement with the local pharmacy and any discrepancies fed back to the pharmacy. The RN signs a checklist to verify reconciliation of medications. The facility uses a robotics pack medication management system for the packaging of all tablets. The facility does not have standing orders. Eyedrops and other liquid medications were dated on opening as evidenced in the medication trolley and fridge. The facility utilises a paper-based medication management system. Ten medication profiles were reviewed. All medication charts reviewed had photo identification and allergy status documented. Prescribed medication is signed after being administered, as witnessed on the day of the audit. All 'as required' medication prescribed had indications for use documented by the GP. Effectiveness of 'as required' medication administered was documented in the progress notes.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a fully equipped kitchen. All meals and baking are prepared and cooked on site by a cook/senior caregiver. There was one cook/senior caregiver who works Monday to Friday 7.00 am to 3.00 pm and a weekend cook/senior caregiver who works 8.00 am to 1.00pm. The cook had completed food safety and hygiene training. There was a tea shift person who works 4.00 pm to 7.00 pm, seven days a week to

		serve and manage the evening meal. The main meal of the day is served at lunch time. There is a four weekly rotating menu in operation that has been amended to reflect resident preferences and has been reviewed by the dietitian. A diary records any menu changes. Currently there were no special dietary requirements. All food was served directly from the kitchen to residents in the dining room or to their rooms as required. A tray service is available if required by residents. All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six monthly as part of their care plan review. Changes to residents' dietary needs are communicated to the kitchen staff. Fridge and freezer temperatures are monitored and recorded daily. End-cooked temperatures are taken and recorded. Reheating/serving temperatures are checked. All perishable goods are date labelled as sighted. A kitchen cleaning schedule is maintained. The food control plan and verification is scheduled for September 2019 as advised by the current owner/manager. Resident's weights are recorded routinely each month or more frequently if required. Residents and relatives interviewed reported satisfaction with food choices and meals, which were well presented. There is an established system in place, the prospective owner does not have any environmental changes planned for the kitchen and meal service.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service has a process for declining entry should this be necessary. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. Management have not had to decline entry to prospective rest home residents. The reason for declining service entry to residents would be recorded and communicated to the resident/family/whānau and alternative options suggested if appropriate.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are	FA	An initial nursing assessment and care plan is completed within 24 hours of admission by the RN. There are a range of assessment tools

gathered and recorded in a timely manner.		completed on admission and reviewed six monthly or earlier if the resident's health status changes. Assessments are conducted in an appropriate and private manner. InterRAI assessments had been completed for four of the five resident files reviewed (link 1.3.3.3). Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the care plan (link1.3.5.2). Vital signs and weights were monitored on a weekly to monthly basis dependant on needs. The general practitioner completes a medical admission (link 1.3.3.3). All residents and relatives interviewed were satisfied with the assessment process. Assessment process and the outcomes are communicated to staff at shift handovers and through the clinical record.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	Residents' LTCPs reviewed were resident-focused and individualised. Care plans documented all the required supports/needs, goals and interventions to reflect the resident's current health status in two of the five resident files. Long-term care plans evidenced resident and/or relative involvement in the development of care plans. Staff interviewed reported they found the plans easy to follow. Short-term care plans (STCP) were sighted for short-term needs and these were either resolved or transferred to the LTCP. All current STCPs were written and signed by the RN. Activities care plans were completed for all files reviewed. Resident files demonstrated service integration and evidence of allied health care professionals involved in the care of the resident such as mental health services for the older person team, podiatrist and physiotherapist.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The RN and caregivers follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required, the RN will initiate a referral (eg, to the wound care nurse specialist or the mental health team). If external medical advice is required, this will be actioned by the GP. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, GP visits and changes in medications. Discussions with families and notifications are

		documented on the family contact form in the residents' files reviewed. Sufficient continence products are available and resident files reviewed included a continence assessment and plan as part of the plan of care. Specialist continence advice is available through the DHB as needed and this could be described. Staff have access to sufficient medical supplies (eg, dressings). There were no residents with wounds on the day of the audit. Access to specialist advice and support is available as needed on referral, including physiotherapy, mental health services and dietitian. Interviews with the RN and caregivers demonstrated understanding of the individualised needs of residents. Monitoring forms reviewed included two hourly turning charts, monthly weight and vital sign monitoring, food and fluid charts, behaviour charts and daily care review charts, however neurological observations had not been completed for unwitnessed falls (link 1.2.4.3). Residents and family members interviewed expressed their satisfaction with the care.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service employs an activities coordinator ten hours per week, to coordinate and implement an afternoon activities programme. The programme is flexible and meets the resident preferences as discussed at the monthly resident meetings. Group activities are provided in the large communal dining room, in seating areas, and outdoors in the gardens when weather permits. Individual activities are provided in resident's rooms or wherever applicable. On the day of the audit residents were observed being actively involved with a variety of activities including bingo and exercises. The group activities programme is developed monthly and a copy of the programme is available in the lounge and on the noticeboard. The group programme includes residents being involved within the community with social clubs, churches and schools. There are exercise sessions each afternoon (balloon games, golf, walks, magnetic darts) followed by newspaper reading and an activity. Activities such as discussion, word builders, quizzes, and crafts follow a chosen topic for the month, for example seasons, colours, animals/birds/nature. Gardening activities are weather dependent. There are community visitors, including a minister who takes reading

		and prayer. There are weekly on-site church services. The service hires a taxi van for weekly scenic drives. The resident under 65 has an individual activity plan including individualised interests and stimulating activities. The resident joins in activities as desired, however prefers watching other residents engaged in activities and has a DHB funded mental health worker who visits weekly. On interview the caregiver stated that the activities programme was well suited to the resident and acknowledged the progress the resident has made since admission. A resident activity assessment is completed on admission. Each resident has an individual activity plan which is reviewed six monthly. Monthly activity progress notes were evidenced in the five resident files sampled. The service receives feedback on activities through one-on-one feedback, resident's meetings and surveys. Residents and family members interviewed were satisfied with the activities and enjoy the weekly scenic drives.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The RN evaluates initial care plans within three weeks of admission and a LTCP developed. Written evaluations identified if the desired goals had been met or not. The GP reviews the residents at least three monthly or earlier, however one resident had not been reviewed by the GP for more than three months (link 1.3.3.3). Ongoing nursing evaluations occur as indicated and are documented within the progress notes. The RN reviews care staff progress notes regularly. Short-term care plans were evident for the care and treatment of residents. Short-term care plans were in place for one resident with pain management issues. Family contact forms reviewed reflect that the family are informed of GP reviews and resident incidents and progress.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to medical and non-medical services. The RN interviewed confirmed that residents, family and the resident's GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to medical specialists are made by the GP in consultation with the RN. Referral documentation is maintained on residents' files and was evident in resident files sampled. Relatives and residents interviewed stated they are informed of referrals

		required to other services and are provided with options and choice of service provider where applicable.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies and procedures in place for waste and hazardous substances management to ensure incidents are reported in a timely manner. Residents, staff and visitors are protected from harm through safe practice. Chemicals are labelled with manufacturer labels. There are designated areas for storage of chemicals and chemicals are stored securely in an outside locked storage room. Product use information was available. Protective equipment including gloves, aprons, and goggles are available for use by staff and was observed being worn by staff while they were carrying out their duties on the day of audit. Staff interviewed were familiar with accepted waste management principles and practices.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness that expires 17 January 2020. Staff complete a general maintenance form for repairs and maintenance requests. Essential contractors are available 24 hours. The owner oversees reactive and planned maintenance. The planned maintenance schedule includes electrical testing and tagging of equipment and annual calibrations. Assessment for hot water temperatures checks are conducted monthly. Hot water is provided at 45 degrees maximum in resident areas (including the two flats). There is a large communal lounge and dining room and a smaller sitting area for residents and families to enjoy. All bedrooms are personalised. There are sufficient communal toilets adjacent to the bedrooms, lounge and dining areas for easy access. There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is easy access to the outdoors. The exterior by the front entrance is well maintained with safe paving, gardens and car parking, the rear entrance had an outdoor deck with shaded seating. There is a designated outdoor resident smoking area. Interviews with the RN and the caregivers confirmed that there was adequate equipment including mobility aids and wheelchairs to carry out the cares

		according to the resident's care plans. The prospective owner does not have plans for any structural changes to the facility. There is a planned maintenance and equipment schedule to be implemented in six months.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	The resident's rooms are in two wings. One bedroom and the two flats have ensuites. All other resident rooms except for two have hand basins. There are adequate numbers of communal shower rooms and toilets. There are privacy locks and labels on the doors. Residents confirmed staff respect their privacy while attending to their hygiene cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All rooms are single and spacious enough to meet the assessed needs of residents. Residents and families are encouraged to personalise their rooms as viewed on the day of audit. There is adequate room for residents to safely manoeuvre using mobility aids. Caregivers interviewed reported that rooms have sufficient space to allow cares to take place. Resident rooms are refurbished as they become vacant.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a large lounge and dining room and small seating areas which are used for activities, recreation and dining activities. The dining room is spacious and located directly off the kitchen/server area and opens to the outdoor decking area. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed reported they can move around the facility and staff assist them if required.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is	FA	There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate outdoor laundry area, with a defined clean/dirty area where all linen and personal clothing is laundered by the caregivers. Caregivers

being provided.		complete laundry and cleaning tasks. The laundry equipment is serviced regularly. Chemicals for laundry and cleaning are purchased from an approved supplier. Staff attend infection prevention and control education and there is appropriate protective clothing available. The effectiveness of the cleaning and laundry processes are monitored through internal audits, resident meetings and surveys. Manufacturers' data safety charts are available for reference if needed in an emergency. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the facility.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The service has an emergency and business continuity plan, last reviewed in April 2019. There is a staff member with a current first aid certificate on duty 24/7. There is an approved fire evacuation scheme in place. Fire safety training has been provided. Fire evacuation drills have been conducted six monthly, last occurring on 1 May 2019. Civil defence and first aid kits are available and are checked annually. Sufficient water and dry food are stored for emergency use and alternative heating and cooking facilities (gas hobs in the kitchen) are available. Emergency lighting is installed and available. A call bell light over each door and a panel alerts staff to the area in which residents require assistance. Visitors and contractors sign in at reception when visiting. Security checks are conducted each night by staff. The front door is locked, and a keypad code is prominently displayed for residents and visitors to exit freely. The front door is connected to the fire system. There is a resident register in place.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All communal and resident bedrooms have external windows with plenty of natural sunlight. The facility is heated by a mix of central heating and wall panels. Windows and ranch sliders open for ventilation. The general living areas and resident rooms were appropriately heated and ventilated on the day of audit. Residents and family interviewed stated the environment is comfortable.

Standard 3.1: Infection control management 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.	FA	Hillcrest Rest Home has an established infection control programme with content and detail that is appropriate for the size, complexity and degree of risk associated with the service. The RN and owner/manager share the infection control responsibilities. The infection control job description has identified delegated responsibility for infection control within the service. The infection control coordinator provides a three-monthly report of all infection events to staff. The infection control programme is reviewed annually. Visitors are asked not to visit if they have been unwell. Influenza vaccines are offered to residents and staff. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. There have been no outbreaks since the last audit.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	Infection control is managed by the infection control coordinator (RN). The infection control coordinator has maintained current knowledge of infection prevention and control. The infection control coordinator has access to infection control personnel within the district health board, laboratory services and the GP who monitors the use of antibiotics.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control policies include a range of standards and guidelines including defined roles and responsibilities for the prevention of infection and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by an aged care consultant and reviewed annually.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. Infection control education has been provided in the past year. Staff receive education on orientation and one on one training as required. Resident education occurs as part of providing daily cares and at resident meetings such as use of sanitisers and hand washing. Hand hygiene posters have been

		placed in all resident toilet areas.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. The infection control coordinator collects the infection rates every three months, identifies trends and uses the information to initiate quality activities within the facility including training needs. The GP receives a copy of the three-monthly summary of infections and antibiotic usage which is signed and returned. The RN and caregivers interviewed were aware of infection rates and infection control practises. Systems are in place that are appropriate to the size and complexity of the facility. There have been no outbreaks since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Hillcrest Rest Home has restraint minimisation and safe practice policies and procedures in place. The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. On the day of the audit there were no residents requiring the use of a restraint or enabler. The RN oversees the enabler/restraint process within the facility. Staff received training on restraint minimisation in March 2019 and challenging behaviour management in February 2019.

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 1.2.4.3 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.	PA Moderate	There is an incident reporting policy that includes definitions and outlines responsibilities. Ten accident/incident forms for the month of June and July 2019 were reviewed. The accident/incident forms reviewed document timely RN review and follow-up. However neurological observations were not completed for four unwitnessed falls with a potential head injury. Three resident falls reviewed did not have an accident/incident form completed.	(i). Neurological observations were not completed for four unwitnessed falls with a potential head injury. (ii). Three resident falls reviewed did not have an accident/incident form completed.	(i). Ensure that neurological observations are completed for any unwitnessed falls with a potential head injury. (ii). Ensure that any resident falls have an accident/incident form completed 60 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing,	PA Low	There are policies and procedures in place for all aspects of medication management. There was one medication fridge in the facility that was in the medication room. The	There was no documented evidence that medication fridge temperatures were regularly monitored.	Ensure medication fridge temperatures are regularly monitored and recorded.

dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		medication fridge temperatures were not regularly monitored.		90 days
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.	PA Low	All initial assessments and care plans had been completed in the five resident files (including one on a mental health contract), however not all interRAI assessments and care plans were completed within the required timeframe for ARC residents. The GP had not seen two residents within five days of admissions and one resident had a longer than three month wait between GP visits.	(i) Four long-term residents did not have interRAI assessments and LTCP completed within 21 days of admission. (ii) Two residents did not have routine six monthly interRAI assessments completed on time. (iii) Two residents were not seen by the GP within five days of admission and one resident had a longer than three months wait between GP visits.	(i) – (ii) Ensure interRAI assessments and care plans are completed within the required timeframes. (iii) Ensure residents are seen by the GP within five days of admission. 90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	Two of five long-term resident files reviewed reflected the supports/needs and interventions to meet the resident current health status. Three LTCPs did not include interventions to support all the residents' current needs and interventions to safely guide staff in the delivery of care.	(i) One resident with challenging behaviours did not have a behaviour plan in place, including identification of triggers and strategies to address challenging behaviours. (ii) One resident with documented weight loss did not have interventions in place for weight loss management. (iii) One resident recognised	Ensure there are documented interventions to support the resident's current needs and health status. 90 days

			as a high falls risk did not have the LTCP updated to reflect current falls risk and falls prevention strategies.	

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.