Taslin NZ Limited - Hillcrest Rest Home

Introduction

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

The audit has been conducted by 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: Taslin NZ Limited

Premises audited: Hillcrest Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 16 July 2021 End date: 16 July 2021

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: 15

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
	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
	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

Hillcrest Rest Home is owned by Taslin NZ Limited. Hillcrest Rest Home provides rest home level care for up to 20 residents. On the day of the audit there were 15 residents.

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

Residents and families interviewed were complimentary of the care and support provided. The owner/manager and clinical nurse manager are well qualified for their roles.

This audit identified that improvements are required around; medication management and emergency management (water tank).

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

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

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

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

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

A 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. There are processes in place to manage medications 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

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.		Some standards applicable to this service partially attained and of low risk.

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 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

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

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

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 management system is appropriate for the size and complexity of the service. The infection control coordinator (clinical nurse manager) working together with the registered nurse, 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. There had been education pertaining to covid and required actions. 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 and the covid 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	43	0	1	1	0	0
Criteria	0	91	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
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 seven staff, including one registered nurse (RN), two healthcare assistants (HCA), one activities coordinator, one administrator, one HR/administrator and one cook confirmed their familiarity with the Code. Staff have completed training on the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The service has established policies and procedures relating to informed consent and advanced directives. All files reviewed included signed informed consent forms and resuscitation instructions. Staff 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 general practitioner (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 clinical nurse manager, RN and health care assistants

		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 have completed training on advocacy support.
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 The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and procedures have been implemented and residents and their family/whānau are provided with information on admission. Complaint forms are visible at the entrance of the facility. A complaints register is maintained. There have been two complaints (March 2021) made since the last audit. The two complaints were made through the Health and Disability Commissioner (HDC). The service investigated and completed corrective actions and responded to HDC on 19 March 2021. At the time of the audit the service had not received a response from HDC. The complaints are still open. The residents and family/whānau interviewed were aware of the complaints process and to whom they should direct complaints.
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, clinical nurse 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. Five residents and two family members interviewed confirmed the services being provided are in line with 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 have completed training on abuse and neglect.
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. Files of two residents that identified as Māori were reviewed and included a Māori health plan. 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. The managers encourage open communication between staff, family/whānau and residents to promote early identification of any concerns.
Standard 1.1.8: Good Practice	FA	The service meets the individualised needs of residents with needs relating to rest home level care. The

Consumers receive services of an appropriate standard.		organisation has developed and implemented policies, procedures, and service delivery and clinical processes and systems that ensure there is a quality of service provided. All residents and family /whanau interviewed praised the staff for the difference the service makes to their life. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-service training. Three monthly staff and quality/management, monthly operation/health and safety and bi-monthly residents meetings are conducted. Staff interviewed stated that they feel supported by the management team. 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, clinical nurse manager and staff are approachable and available. Fifteen 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 bi-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 is owned by Taslin NZ Limited who also own Otatara Heights Residential Care. Hillcrest Rest Home provides care for up to 20 rest home level residents. On the day of audit there were 15 rest home residents. There were two residents on mental health contracts, one resident on an ACC contract and one resident on a long-term support chronic health condition contract (LTS-CHC). All other residents were under the aged related residential care (ARRC) contract. The governance and quality plan 2019/2021, which is reviewed annually, outlines the purpose, values, scope, philosophy, direction, and goals of the organisation. The documents described annual and long-term objectives and the associated operational plans. A sample of the report to the management group showed adequate information to monitor performance is reported, including financial performance, quality data, staffing, emerging risks, and issues. A full governance review, which includes all managers and both owners, is undertaken on a regular basis with the last one being held in January 2020. The service is managed by an owner/manager who has owned the business since September 2019 and has worked in aged care for 20 years with experience in dealing with mental health residents. She is supported by a clinical nurse manager who has a post graduate qualification in aged care and has worked in aged care for over 20 years. The owner/manager and clinical nurse manager are also supported by an RN, administration manager and administrator/HR. The owner/manager and clinical

		nurse manager confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through regular ongoing education related to the roles they have undertaken. The manager/owner and clinical nurse manager have completed in excess of eight hours of professional development in the past 12 months.
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 clinical nurse manager or RN fills the role with support from the care staff.
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 service has a planned quality and risk system that reflects the principles of continuous quality improvement. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Monthly data is collected on complaints, accidents, incidents, infection control and is provided to staff to read and sign. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality/management, operation/H&S and staff meetings. Discussions with HCAs confirmed their involvement in the quality programme. Resident/family meetings occur bi-monthly. Resident and family satisfaction surveys are completed annually and were undertaken in May 2021. Both surveys indicated that residents and families were happy with the quality of care and food service being provided. The internal audit schedule for 2021 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. Health and safety goals are established and regularly reviewed at the monthly operation/H&S meeting. Hazard identification forms are completed for any accidents or near misses and an up-to-date hazard register was in place. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.

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.	FA	There is an incident reporting policy that includes definitions and outlines responsibilities. Fifteen accident/incident forms for the month of May, June and July 2019 were reviewed. Accident/incident forms reviewed for three medication errors reported, did not include follow up action/investigation (Link 1.3.12.1). The clinical nurse manager investigates accidents and near misses and provides a monthly analysis and trends of incident/accidents. There is a discussion of incidents/accidents at the quality/management, operation/H&S and staff meetings. Appropriate care and support have been provided by caregivers and RNs post incident. 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 have been no section 31 notifications lodged since the last audit.
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. This includes that the recruitment and staff selection process require that relevant checks be completed to validate the individual's qualifications, experience, and veracity. A copy of practising certificates is kept. Five staff files (one RN, three HCAs and one activities coordinator) were reviewed. All files include documentation that reflected good employment processes. Annual staff appraisals were evident in all staff files reviewed. Completed orientation is on files and staff described the orientation programme. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2020 has been completed and the plan for 2021 is being implemented. The owner/manager, clinical nurse manager and RN are able to attend external training, including sessions provided by Hawkes Bay DHB. Discussions with the HCAs confirmed that ongoing training is encouraged and supported by the service. There are 11 HCAs in total with four having completed level 4 and one has completed level 3 NZQA National Certificate. At the time of the audit four HCAs were enrolled to complete level 3. The RN has completed interRAI training. The HCAs complete competencies relevant to their role such as medication competencies. Staff training has included sessions around community participation and supporting residents to live full lives.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service	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. There are 20 staff in total with eight being shared with Otatara Heights. The clinical nurse manager and RN work 8 hours on Tuesday and Friday respectively with the owner/manager working on days that the clinical nurse manager and RN are not there. There is always a manager available on site at Hillcrest Rest Home with the administration manager and owner/maintenance also working on site when needed.

providers.		The owner/manager and administration manager share the on-call cover for any operational needs. The clinical nurse manager and RN rotate the on-call duties for any clinical issues. The owner/manager, clinical nurse manager and RN are supported by two HCAs on the morning and afternoon shifts and one HCA on the night shift. There is always a minimum of one care staff trained in first aid on duty. Interviews with the residents and family members confirmed staffing overall was satisfactory. The HCAs interviewed stated that they have sufficient staffing levels.
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 (e.g., 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	PA Moderate	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

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		locked access. The medication fridge temperature and room temperature are monitored and recorded. The senior HCAs 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 an electronic medication management system. Ten medication profiles were reviewed. All medication charts reviewed had photo identification. Six medication charts did not indicate if any allergies were known. All 'as required' medication prescribed had indications for use documented by the GP. Effectiveness of 'as required' medication administered is documented. Medication errors are reported through the accident and incident event reporting process. Three such reported incidents reviewed evidenced no follow up investigation or action.
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. There was one cook who works Monday to Friday 7.00 am to 3.00 pm and a weekend cook who works 7.00 am to 1.00pm. The cook had commenced two weeks prior to audit and was still completing orientation. She had previously worked in a commercial food handling role. To date she had undertaken handwashing and chemical handling and on audit demonstrated a good understanding of safe food handling. 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 seasonal menu in operation that has been reviewed by the dietitian (June 2021). A diary records any menu changes. 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 by Hastings District Council occurred June 2021. 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.

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 gathered and recorded in a timely manner.	FA	All appropriate personal needs information is gathered during admission. In the files reviewed, the interRAI assessment tool had been used for all residents admitted under the ARRC agreement. A suite of assessment tools including, falls assessment, pressure assessment, pain and dietary assessment were used for the residents who were not on the ARRC contract. A nursing assessment and care plan were completed on admission. As well as using interRAI assessments, the residents' files also included a full range of assessments to assist with resident care planning. Files reviewed identified that risk assessments have been completed on admission and reviewed six monthly as part of the evaluation.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	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. 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 used for short-term needs and these were either resolved or transferred to the LTCP. STCPs were used for infections, wounds, use of antibiotics and acute conditions e.g. fractured hip where there is an acute change with a short term outcome. 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, occupational therapist and physiotherapist.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs	FA	The RN and HCAs 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 (e.g.: 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'

and desired outcomes.		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 (e.g., dressings). There was one resident with a wound 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 HCAs 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 and behaviour charts. 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 (a qualified diversional therapist) 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 lounge /dining area, 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 listening to an entertainer. 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 at least a weekly outing to play bowls, pool and/or ten pin bowling, lunch at McDonalds and visits to meet with residents from their sister home are among a number of activities on the programme. There are exercise sessions (balloon games, golf, walks, magnetic darts) followed by newspaper reading and an activity. Activities such as creative writing, word builders, quizzes, and crafts follow a chosen topic for the month, for example seasons, colours, animals/birds/nature. The service uses a van that is shared with their sister home and also hires a taxi van for outings. The resident who is funded by ACC is under 65, and has an individual activity plan including individualised interests and stimulating activities. The resident goes out keeping involved with friends and activities or otherwise prefers to remain in his unit watching TV/ listening to music or reading the newspaper which is delivered to him. 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 spoke positively of the activities.
Standard 1.3.8: Evaluation	FA	The RN evaluates initial care plans within three weeks of admission and a LTCP is developed. Written

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		evaluations identified if the desired goals had been met or not and were detailed. The GP reviews the residents at least three monthly or earlier. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. The RN reviews care staff progress notes. Short-term care plans were evident for the care and treatment of residents. Family contact forms reviewed reflect that the family are informed of GP reviews (their input is invited) 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 1 January 2022. 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. Hot water temperatures checks are conducted monthly. Hot water is provided at 45 degrees maximum in resident areas. 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 HCAs confirmed that there was adequate equipment including a sling hoist, mobility aids and wheelchairs to carry out the cares according to the resident's care plans. Extensive refurbishment/decoration has occurred over the last eighteen 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. Healthcare assistants 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	FA	There are documented systems for monitoring the effectiveness and compliance with the service policies

Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		and procedures. There is a separate outdoor laundry area, with a defined clean/dirty area where all linen and personal clothing is laundered by staff. A dedicated cleaner/laundry person undertakes laundry and cleaning tasks four days a week 9.30am to 1.00pm. Healthcare assistants undertake the duties for the balance of the week. 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. 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.	PA Low	The service has an emergency and business continuity plan in place. 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 February 2021. Civil defence and first aid kits are available and are checked six monthly. Sufficient dry food are stored for emergency use and alternative heating and cooking facilities (gas hobs in the kitchen) are available. The service has installed a 900-litre water tank to provide sufficient water supply for 10 litres per person for 3 days. Emergency lighting is installed and available for up to four to eight hours (this was upgraded in 2021). 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	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 clinical nurse

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.		manager and owner/manager share the infection control responsibilities. The clinical nurse manager has a signed position description for the role of infection control coordinator. The infection control coordinator provides a report of all infection events to staff and operations meetings. The infection control programme is reviewed annually. Visitors are asked not to visit if they have been unwell. Influenza vaccines and covid vaccines have been offered to residents and staff. Covid-19 vaccinations were booked to occur the week following audit. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. There have been no outbreaks since the previous audit. Additional supplies of PPE equipment were readily available from the store at the local sister home.
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 (clinical nurse manager). 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, regional health, laboratory services and the GP who monitors the use of antibiotics. The DHB infection control (IC) nurse specialist had been involved with providing information on covid and also with training staff. Along with 1:1 meetings with the IC nurse specialist, infection control coordinator and RN had had zoom meetings with DHB personnel.
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 the clinical nurse manager and owner/manager with information from a number of sources. The service has worked with the Hawkes Bay Navigator team and had lodged a pandemic plan with the DHB.
Standard 3.4: Education	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff.

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.		Infection control education has been provided in the past year by the IC nurse specialist from HBDHB. 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.
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 monthly, identifies trends and uses the information to initiate quality activities within the facility including training needs. The RN and HCAs 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 previous 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. Staff received training on restraint minimisation and challenging behaviour management in 2021.

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 1.3.12.1 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 Moderate	There are policies and procedures in place for all aspects of medication management including the documentation of allergies/or of nil known allergies on the medication chart and the process of reporting medication errors through the accident and incident reporting process.	i). Six of ten medication charts reviewed had no record of allergies known or not known. ii). Three medication errors reported via the accident and incident reporting system evidenced no follow up action/investigation or corrective action.	i). Ensure medication charts include relevant information such as allergies. ii). Ensure any medication errors are followed through with an

				investigation and outcome. 60 days
Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.	PA Low	The service has an emergency and business continuity plan. Civil defence and first aid kits are available and are checked six monthly. Sufficient dry food are stored for emergency use and alternative heating and cooking facilities (gas hobs in the kitchen) are available.	The service has installed a 900-litre water tank however at the time of the audit the water tank was empty and needs to be put on a platform to enable the tap to be fully accessed.	Ensure that the water tank is filled and put on a platform so that the tap can be accessed. 60 days

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.