**Bizcomm New Zealand Limited**

**Current Status:** **03-Jul-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Certification audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.**

**General overview**

Manor Park Private Hospital is certified for hospital level care for up to 54 psychogeriatric and mental health residents. On the day of audit there were 47 psychogeriatric residents. The manager is a registered nurse and is supported by a care-coordinator (registered nurse), and quality improvement co-coordinator.

There is an implemented quality and risk management programme that includes analysis of incidents, accidents, complaints, hazards and an implemented health and safety programme. Improvements to service delivery are sighted as a result of the quality programme.

There are registered nurses on duty 24 hours a day. Staffing is as per the staffing policy and has been adjusted with extra staff allocated at times when there are higher support needs of residents.

The following improvements are required by the service related to; advance directives, dementia training, assessment of pain, medication, chemicals and checking of equipment.

**Audit Summary AS AT** **03-Jul-13**

Standards have been assessed and summarised below:

**Key**

| **Indicator** | **Description** | **Definition** |
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|  | 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 |
|  | 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 |

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| **Consumer Rights** | Day of Audit  03-Jul-13 | Assessment |
| 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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Organisational Management** | Day of Audit  03-Jul-13 | Assessment |
| 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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Continuum of Service Delivery** | Day of Audit  03-Jul-13 | Assessment |
| 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** |

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| **Safe and Appropriate Environment** | Day of Audit  03-Jul-13 | Assessment |
| 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** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  03-Jul-13 | Assessment |
| 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** |

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| **Infection Prevention and Control** | Day of Audit  03-Jul-13 | Assessment |
| 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** |

**Audit Results AS AT** **03-Jul-13**

**Consumer Rights**

Residents receive services in accordance to consumer rights legislation. The information around the code and advocacy services is displayed and is easy to access. Residents physical, visual, auditory and personal privacy is respected. There is a documented complaints procedure which complies with the Health and Disability Code and information around this is well displayed for residents with forms available. Implementation of an organisational database ensures all complaints are monitored and closed out as required. Systems are in place to ensure clients, and where appropriate their family, are being provided with appropriate information to assist them to make informed choices and give informed consent.

Family members interviewed stated that a key strength of the service is the ability to provide residents with choice, respect, privacy and confidentiality.

There are improvements required around advance directives.

**Organisational Management**

There is a documented values and a mission statement that focuses on providing the highest standard of personal and individual care to each resident and to maintain the dignity and wellbeing of each resident. The owner of the service has a background as a lawyer and provides a support for the manager with meetings on site each one to two days. The manager is a registered nurse with post graduate diplomas and experience in management and aged care and is supported by senior leaders including an registered nurse with qualifications in mental health.

Manor Park private Hospital has a quality and risk management system in place that is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to the facility meetings including quality management, health and safety and staff meetings. Corrective actions are identified and implemented.

Human resource policies are in place with recruitment as per policy. There is an orientation and training programme that provides staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care. The roster has been adjusted over the last year to allocate better staffing when there are more needs or support required.

An improvement is required to training around dementia.

**Continuum of Service Delivery**

The service has a well-developed assessment process and resident's needs are assessed prior to entry for psychogeriatric or mental health level of care. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Relatives confirmed the admission process and the admission agreement was discussed with them. Registered nurses are responsible for each stage of service provision.

Residents' files reviewed provide evidence that the provider has systems to assess, plan and evaluate care needs of the residents. There is an improvement required around the completion of pain assessments for new or increased episodes of pain. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed with the resident (if appropriate) and family/whanau three monthly. Coordinated care plans are developed and demonstrate service integration and guide all staff in cares. Resident files include notes by the GP and allied health professionals.

Medicines are managed and policies reflect legislative requirements. Registered nurses are responsible for administration of medicines and complete annual medication competencies and education. The medicines records reviewed include documentation of allergies and sensitivities, photo identification, and special instructions for administration. There is an improvement required around GP three monthly review of medication charts and standing orders.

The activities programme is facilitated by a diversional therapist and two activities coordinators. The activities programme provides activities that meet the consumer groups in each unit. Residents have an individualised 24 hour activity plan. Links with the community are encouraged where appropriate and van outings are arranged on a regular basis. All food is prepared and cooked on site by the cooks and their kitchen hands. All residents' nutritional needs are identified and accommodated with alternative choices provided. Meals are well presented, homely and the menu plans have been reviewed by a dietitian. There are nutritious snacks available 24 hours for the residents as required. Food and fridge temperatures are recorded.

**Safe and Appropriate Environment**

There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals are stored appropriately and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and current approved evacuation scheme approval. The service provider's documentation evidences appropriate systems are in place to ensure the consumers' physical environment and facilities are appropriate for their purpose. Documented evidence is available to indicate that hot water temperatures are being monitored and recorded on a regular basis. Three items of resident related equipment require a functional check. Residents and family interviewed state the facility is warm and comfortable. The psychogeriatric units are safe, secure and purpose built with access to external walking paths, courtyards and seating. The indoor communal areas accommodate group and individual activities. There are adequate numbers of toilets/showers and bathroom within each unit. Bedrooms are spacious and personalised. There is a chapel/family/whanau room. The facility has a hydrotherapy pool.

Improvements are required to chemicals and checking of equipment.

**Restraint Minimisation and Safe Practice**

The organisation has policies and procedures that is around not using restraint. All staff receive training on de-escalation and management of challenging behaviours and there is no evidence to suggest that restraint is used. There are no enablers or restraint used in the service. The service has maintained a restraint free environment for a year. Challenging behaviours are managed according to plans documented as required.

**Infection Prevention and Control**

The infection prevention and control programme is evaluated and reviewed for its continuing effectiveness and appropriateness. The position of infection control co-ordinator is assigned to a registered nurse. The infection prevention and control policies and procedures are documented and reviewed. Staff and the infection control coordinator have training relevant to their roles. Infection prevention and control is expected to be discussed monthly at the quality and health and safety meetings which are held as sighted in minutes documented. Surveillance data is documented and a review of the data indicates that there is a low infection rate.

**Manor Park Private Hospital**

Bizcomm New Zealand Limited

Certification audit - Audit Report

Audit Date: 03-Jul-13

**Audit Report**

To: HealthCERT, Ministry of Health

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| **Provider Name** | Bizcomm New Zealand Limited |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Manor Park Private Hospital | 14 Manor Park Road | Manor Park | Lower Hutt |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 03-Jul-13 **End Date:** 04-Jul-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

**Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXX | MBA MN B Ed Adv Dip Child and Family RGON Dip Tchg | 12.00 | 8.00 | 03-Jul-13 to 04-Jul-13 |
| Auditor 1 | XXXXXXX | RN, Health audit cert | 12.00 | 7.00 | 03-Jul-13 to 04-Jul-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor | XXXXXXX |  | 12.00 | 6 | 03-Jul-13 to 04-Jul-13 |
| Peer Review Auditor | XXXXXXX |  |  | 3.00 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 36.00 | **Total Audit Hours off site** *(system generated)* | 24.00 | **Total Audit Hours** | 60.00 |
| **Staff Records Reviewed** | 9 of 75 | **Client Records Reviewed** *(numeric)* | 8 of 52 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 8 |
| **Staff Interviewed** | 12 of 75 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 8 |
| **Consumers Interviewed** | 2 of 52 | **Number of Medication Records Reviewed** | 16 of 52 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

**Declaration**

I, (full name of agent or employee of the company) XXXXXXX (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofHealth and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health and Disability Auditing New Zealand Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 5 day of August 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit: 🗷

The audit summary has been developed in consultation with the provider: 🗷

Electronic Sign Off from a DAA delegated authority (*click here*): 🗷

**Services and Capacity**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit \*\*** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Manor Park Private Hospital | 54 | 52 |  | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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\*\* For DHB audits: Day of audit is to be day one (1).

**Executive Summary of Audit**

*General Overview*

Manor Park Private Hospital is certified for hospital level care for up to 54 psychogeriatric and mental health residents. On the day of audit there were 47 psychogeriatric residents. The manager is a registered nurse and is supported by a care-coordinator (registered nurse), and quality improvement co-coordinator.

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There are registered nurses on duty 24 hours a day. Staffing is as per the staffing policy and has been adjusted with extra staff allocated at times when there are higher support needs of residents.

The following improvements are required by the service related to; advance directives, dementia training, assessment of pain, medication, chemicals and checking of equipment.

*1.1 Consumer Rights*

Residents receive services in accordance to consumer rights legislation. The information around the code and advocacy services is displayed and is easy to access. Residents physical, visual, auditory and personal privacy is respected. There is a documented complaints procedure which complies with the Health and Disability Code and information around this is well displayed for residents with forms available. Implementation of an organisational database ensures all complaints are monitored and closed out as required. Systems are in place to ensure clients, and where appropriate their family, are being provided with appropriate information to assist them to make informed choices and give informed consent.

Family members interviewed stated that a key strength of the service is the ability to provide residents with choice, respect, privacy and confidentiality.

There are improvements required around advance directives.

*1.2 Organisational Management*

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An improvement is required to training around dementia.

*1.3 Continuum of Service Delivery*

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*1.4 Safe and Appropriate Environment*

There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals are stored appropriately and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and current approved evacuation scheme approval. The service provider's documentation evidences appropriate systems are in place to ensure the consumers' physical environment and facilities are appropriate for their purpose. Documented evidence is available to indicate that hot water temperatures are being monitored and recorded on a regular basis. Three items of resident related equipment require a functional check. Residents and family interviewed state the facility is warm and comfortable. The psychogeriatric units are safe, secure and purpose built with access to external walking paths, courtyards and seating. The indoor communal areas accommodate group and individual activities. There are adequate numbers of toilets/showers and bathroom within each unit. Bedrooms are spacious and personalised. There is a chapel/family/whanau room. The facility has a hydrotherapy pool.

Improvements are required to chemicals and checking of equipment.

*2 Restraint Minimisation and Safe Practice*

The organisation has policies and procedures that is around not using restraint. All staff receive training on de-escalation and management of challenging behaviours and there is no evidence to suggest that restraint is used. There are no enablers or restraint used in the service. The service has maintained a restraint free environment for a year. Challenging behaviours are managed according to plans documented as required.

*3. Infection Prevention and Control*

The infection prevention and control programme is evaluated and reviewed for its continuing effectiveness and appropriateness. The position of infection control co-ordinator is assigned to a registered nurse. The infection prevention and control policies and procedures are documented and reviewed. Staff and the infection control coordinator have training relevant to their roles. Infection prevention and control is expected to be discussed monthly at the quality and health and safety meetings which are held as sighted in minutes documented. Surveillance data is documented and a review of the data indicates that there is a low infection rate.

**Summary of Attainment**

* 1. ***Consumer Rights***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | FA | 0 | 4 | 0 | 0 | 0 | 4 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 4 | 0 | 0 | 0 | 4 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.7 | Discrimination | FA | 0 | 4 | 0 | 0 | 0 | 4 |
| Standard 1.1.8 | Good practice | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.10 | Informed consent | PA Low | 0 | 4 | 1 | 0 | 0 | 5 |
| Standard 1.1.11 | Advocacy and support | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.12 | Links with family/whānau and other community resources | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 2 |

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| Consumer Rights Standards (of 13): N/A:0 CI:0 FA:12 PA Neg:0 PA Low:1 PA Mod:0 PA High: 0  PA Crit:0 UA Neg:0 UA Low:0 UA Mod:0 UA High:0 UA Crit: 0  Criteria (of 31): CI:0 FA:30 PA:1 UA:0 NA: 0 |

* 1. ***Organisational Management***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 8 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.2.5 | Consumer participation | FA | 0 | 5 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation | FA | 0 | 3 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | PA Low | 0 | 3 | 1 | 0 | 0 | 4 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 4 |

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| Organisational Management Standards (of 9): N/A:0 CI:0 FA:8 PA Neg:0 PA Low:1 PA Mod:0 PA High: 0  PA Crit:0 UA Neg:0 UA Low:0 UA Mod:0 UA High:0 UA Crit: 0  Criteria (of 30): CI:0 FA:29 PA:1 UA:0 NA: 0 |

* 1. ***Continuum of Service Delivery***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 5 | 0 | 0 | 0 | 5 |
| Standard 1.3.4 | Assessment | PA Low | 0 | 1 | 1 | 0 | 0 | 2 |
| Standard 1.3.5 | Planning | FA | 0 | 3 | 0 | 0 | 0 | 3 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 3 | 0 | 0 | 0 | 3 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.3.8 | Evaluation | FA | 0 | 3 | 0 | 0 | 0 | 3 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) | Not Applicable | 0 | 0 | 0 | 0 | 4 | 4 |
| Standard 1.3.12 | Medicine management | PA Moderate | 0 | 4 | 1 | 0 | 0 | 5 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 3 |

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| Continuum of Service Delivery Standards (of 13): N/A:1 CI:0 FA: 10 PA Neg: 0 PA Low: 1 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:28 PA:2 UA:0 NA: 4 |

* 1. ***Safe and Appropriate Environment***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | PA Low | 0 | 1 | 1 | 0 | 0 | 2 |
| Standard 1.4.2 | Facility specifications | PA Low | 0 | 2 | 1 | 0 | 0 | 3 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.4.4 | Personal space/bed areas | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.4.6 | Cleaning and laundry services | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 5 | 0 | 0 | 0 | 5 |
| Standard 1.4.8 | Natural light, ventilation, and heating | FA | 0 | 2 | 0 | 0 | 0 | 2 |

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| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 6 PA Neg: 0 PA Low: 2 PA Mod: 0  PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 17): CI:0 FA:15 PA:2 UA:0 NA: 0 |

1. ***Restraint Minimisation and Safe Practice***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 1 | 1 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 1 | 1 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 3 | 3 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 2 | 2 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 1 | 1 |
| Standard 2.3.1 | Safe seclusion use | Not Applicable | 0 | 0 | 0 | 0 | 5 | 5 |
| Standard 2.3.2 | Approved seclusion rooms | Not Applicable | 0 | 0 | 0 | 0 | 4 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 8): N/A: 7 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 18): CI:0 FA:1 PA:0 UA:0 NA: 17 |

1. ***Infection Prevention and Control***

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | FA | 0 | 3 | 0 | 0 | 0 | 3 |
| Standard 3.2 | Implementing the infection control programme | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 3.3 | Policies and procedures | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 3.4 | Education | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 3.6 | Antimicrobial usage | Not Applicable | 0 | 0 | 0 | 0 | 2 | 2 |

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| Infection Prevention and Control Standards (of 6): N/A: 1 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 11): CI:0 FA:9 PA:0 UA:0 NA: 2 |

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| --- |
| **Total Standards (of 57) N/A:**9 **CI:**0 **FA:**42 **PA Neg:**0 **PA Low:**5 **PA Mod:**1 **PA High:**0 **PA Crit:**0 **UA Neg:**0 **UA Low:**0 **UA Mod:**0 **UA High:**0 **UA Crit:** 0  **Total Criteria (of 141) CI:** 0 **FA:** 112 **PA:** 6 **UA:** 0 **N/A:** 23 |

**Corrective Action Requests (CAR) Report**

Provider Name: Bizcomm New Zealand Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:03-Jul-13 End Date: 04-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.10 | 1.1.10.7 | PA  Low | **Finding:**  Advanced directives/ resuscitation policy is implemented in five of eight resident files reviewed . One psychogeriatric and two mental health residents advance directives did not evidence discussion with the family/EPOA.  **Action:**  Evidence of family/EPOA discussion is provided to validate the resuscitation status. | 6 months |
| 1.2.7 | 1.2.7.5 | PA  Low | **Finding:**  Two caregivers have not completed dementia training and have been with the service for over six months.  **Action:**  Ensure all staff are enrolled in dementia training within timeframes documented in the ARC contract. | 6 months |
| 1.3.4 | 1.3.4.2 | PA  Low | **Finding:**  One of two resident’s files sampled did not have a pain assessment in place for pain management following a post-operative procedure.  **Action:**  Ensure pain assessments are completed for new episodes of pain. | 3 months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.12 | 1.3.12.1 | PA  Moderate | **Finding:**  i) There are GP orders for bowel management that includes the use of laxatives dated 2004. Nurse initiated medications are administered, however there is no signed GP authority that meets the MOH medication guidelines around standing orders. ii) Five of 16 medication charts did not evidence three monthly review.  **Action:**  i) Ensure that standing orders meet MoH medication guidelines. ii) Ensure there are GP reviews of medication charts three monthly. | 3 months |
| 1.4.1 | 1.4.1.1 | PA  Low | **Finding:**  The cleaners trolley was seen unobserved on occasions throughout day one of the audit. One chemical bottle in Endeavour servery did not have a manufacturer label on it. This was addressed on the day of audit.  **Action:**  Ensure that chemicals are labelled correctly and that the cleaners trolley is visible to staff at all times. | 3 months |
| 1.4.2 | 1.4.2.1 | PA  Low | **Finding:**  Two hoists and platform scales are overdue for a functional check.  **Action:**  Ensure the equipment is checked and deemed safe for use. Since the draft report the manager advised that all equipment was serviced and tested | 1 month |

**Continuous Improvement (CI) Report**

Provider Name: Bizcomm New Zealand Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:03-Jul-13 End Date: 04-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

**1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS**

**OUTCOME 1.1 CONSUMER RIGHTS**

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

**STANDARD 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Residents are spoken to respectfully by name and fair treatment for residents was observed. Residents have access to privacy with a large majority of single rooms which they are able to individually decorate. Two out of two residents understood that they had the right to make a complaint.

Eight of eight family members confirmed that clients are treated with respect and this was observed during the audit.

All staff interviewed including five caregivers all demonstrate a high level of understanding of clients rights and are able to describe how these are put into practice and how the rights of clients as an organisational value is communicated to all staff.

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

A poster on the Code of Rights is visible on the wall within each of the three wings. There is also a pamphlet on the Health and Disability Code of Rights within the Introductory Pack. One of two residents interviewed knew about the Code of Rights and understood that they have the right to legal representation if requested. The other could not remember.

D6,2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy.

ARHSS D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement

**Criterion 1.1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.2.4 Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Residents have private rooms. Auditors observed staff interaction with residents that was respectful and friendly. D3.1b, d, f, i Manor Park has a mission statement that states its aim is to provide the highest standard of personal and individual care to each resident. The service promotes involvement of residents in decisions about their care as much as they can be involved.

D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. Personal belongings such as photos and furniture are encouraged by staff and these were sighted in rooms of residents, including certificates in one resident’s room. Personal belongings are included on personal file on a Register of Property.

**Criterion 1.1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.2 Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🗷 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Manor Park Private Hospital has had good links with Korounui Marae in nearby Stokes Valley. Several attempts have been made to reengage but without success. Manor Park Private Hospital is continuing to try to rekindle relationships. There is an understanding that attempts to link with Korounui Marae will continue.

There is a Maori Health Plan on file which includes an excellent resource on communication. Currently three Maori staff are employed as well as a Tongan staff member who has some knowledge of Te Reo.

Cultural groups provide entertainment and some residents have cultural food prepared for them by the cook. Cultural awareness/safety training is mandatory for all staff.

D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.

ARHSS D4.1b Six of six PG resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified. Seven of seven family members of residents in the PG unit state that their family member’s cultural and spiritual values are upheld.

**Criterion 1.1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.5 The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.7 The service provides education and support for tangata whaiora, whānau, hupu, and iwi to promote Māori mental well-being.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.5 Recognition Of Pacific Values And Beliefs**

Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

A number of staff are noted to have a Pacific background - one Samoan/Niuean staff member is able to use her Samoan language to communicate with one resident. Manor Park Private Hospital has links to a lay minister in the Church (Pacific Island). The cultural folder includes information on Pacific needs.

**Criterion 1.1.5.1 The service delivers and facilitates appropriate services for Pacific consumers and recognises the fundamental importance of the relationships between Pacific consumers, their families, and the community. This shall include, but is not limited to the service:**

(a) Developing effective relationships with Pacific people to support active participation across all levels;

(b) Where appropriate, developing services that are based on Pacific frameworks/ models of health that promotes clinical and cultural competence;

(c) Ensuring access to services based on Pacific people's need and planning and delivering services accordingly;

(d) Developing a culturally enhanced workforce that will respond effectively to the needs of Pacific consumers. This may include actively recruiting and employing service providers with links to Pacific people and providing suitable education/training/mentoring of service providers to respond to specific cultural requirements and preferences.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.5.2 The service provides education, training, and support to Pacific people or other agencies to promote the well-being of Pacific people.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🗷 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

A Life History form is included within the information pack for families to complete. This information is incorporated into the care plan and includes preferred name, schools, employment, interests, background lifestyle (and various other questions on spirituality, culture and socialisation). Policies and related documents include: Cultural and Spiritual Service Policy and related information within a Cultural Folder. There is a brief Guide to Religious Practices, a practice article on Meeting Patients Religious Needs and a guide to Understanding Cultural Safety. Manor Park Private Hospital has its own Chapel and has links with Pastoral Services which are held once a fortnight. One resident is taken to Mass on a weekly basis.

Residents are encouraged to bring personal belongings i.e. family photos, furniture. Male residents have access to a Men’s Group that meet regularly.

Staff try to engage residents as much as possible in activities that they are familiar with and this includes cultural and spiritual activities.

One family member mental health and seven of seven PG family members state that their family member is treated with respect. They state that 'staff have infinite patience and understanding particularly in the PG unit.

Staff were observed to be managing some challenging behaviour on the days of the audit and at all times, residents were treated with respect and dignity.

Five of five caregivers describe strategies used to manage challenging behaviour both for residents with mental health issues and residents in the PG unit. These are respectful and they talk of treating the resident as a member of their family and as they would wish to be treated.

**Criterion 1.1.6.2 The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

One of two residents (mental health) interviewed stated that they are invited and not pressured into participating in activities. A higher level of patient centred care was requested from two of two residents interviewed (mental health):

In the PG unit, staff and residents speak of providing residents as much choice as possible including choice of which clothes to wear, to be able to have a sleep in, prompt response to request for support to make phone call (mental health residents), request for help operating TV//DVD (mental health residents).

Family financial responsibility is clearly outlined within the introductory pack e.g. dentist, optician, mobility equipment etc. are additional costs.

ARHSS D16.5e: Five of five caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with .five caregivers could describe how they build a supportive relationship with each resident. Interviews with seven families from the PG unit confirmed the staff assist to relieve anxiety.

Two mental health residents describe ways in which staff support them to access the community and to break down barriers of discrimination.

All staff interviewed are able to describe professional boundaries and how they manage these. Staff interviewed include the owner, the manager, five caregivers, a care coordinator, five registered nurses, one registered nurse coordinator, the diversional therapist, the cook, laundry supervisor and maintenance.

**Criterion 1.1.7.2 Service providers should have an understanding of discrimination. Service providers shall demonstrate knowledge of the barriers to recovery posed by discrimination, which translates into provider systems that promote recovery.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.7.3 Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.7.4 The service does not withdraw support or deny access to treatment and support programmes when or if the consumer refuses some aspects of treatment.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.7.5 The service actively works to identify and address prejudicial attitudes and discriminatory practices and behaviours within its own service and any other service it has links with.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🗷 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Large lounges, smaller rooms, family room, sensory room and smokers rooms are available to residents. Family of residents (psychogeriatric) interviewed state that staff keep a close eye those newly admitted in order for a good orientation for both resident and staff. There are no residents currently under restraint - there is a Restraint Minimisation and Safe Practise Policy.

Eight family members were interviewed (seven psycho-geriatric and one mental health). Of the seven psychogeriatric and one mental health family members, seven said that they were very happy with the service offered. One family member (psycho-geriatric) was ambivalent. All eight of eight family members state that they were kept well informed and that they feel confident that their family member is safe within the care of Manor Park Private Hospital.

One family member stated that their family member is as safe as possible; that the environment is uncluttered, clean, that the staff are visible.

Staff are regularly given performance appraisals and there are clear boundaries set out within the job descriptions for competencies for care workers, enrolled and registered nurses. Staff work in pairs ensuring their personal safety and that of the residents. Staff are aware of policies and procedures. There are regular staff meetings and staff surveys and open communication between staff and management. There is a robust internal audit programme.

A2.2 Services are provided at Manor Park Private Hospital that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D1.3 All approved service standards are adhered to.

D17.7c There are implemented competencies for caregivers and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

The management team stated they care for all residents –both psycho-geriatric and mental health based on a ‘person-centred model of care’. The residents are well supported in the psychogeriatric service with models of care appropriate to their needs. Residents with mental health identified needs have long term and persistent mental illness with institutionalised behaviours.

**Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🗷 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Open communication commences upon resident being admitted. The general practitioner is invited to attend. Family are asked to fill out the Life History form contained within the information pack. Following this a care plan is developed and updated at the multi-disciplinary meeting every 6 months. Contained within is information that aids communication e.g. hand drinks to resident's left hand. Communication witnessed was respectful and includes a mix of both verbal and visual communication. Residents are spoken to politely by name e.g. when asked if they would like a cup of tea.

The manager has an "open door policy". The family members (psychogeriatric) state that (as far as they were aware) they are kept informed at all times.

D16.4b Eight of eight relatives state that they are always informed when their family members health status changes.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – "what you need to know” is provided to residents on entry

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

The five registered nurses interviewed are aware of how interpreters can be accessed if needed and the manager described key information meetings where this had been arranged.

**Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

Policies and training support staff in providing care and support to enable residents to make choices as appropriate to their level of understanding and competency.

There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. The written consent form includes consent to : MDT approach to care, acknowledging CPR with advanced life support is not offered at Manor Park, consultation regarding any changes to health, wellbeing or any appropriate treatment required, for outings and transport, photograph for display and identification, release of information to health professionals and family, nursing students to undertake care duties, receive information about the code of H&D services and consumer rights and the opportunity to participate in care planning.

All eight resident files reviewed have signed consent forms signed by the family/whanau/EPOA. Caregivers (five) and RN's (five) interviewed are knowledgeable in the informed consent policy and offer residents choice as appropriate.

Advance directives/ resuscitation policy is implemented in five of eight resident files reviewed (two mental health and six psychogeriatric).

One psychogeriatric and two mental health residents advance directives did not evidence discussion with the family/EPOA. Advance directives are completed by the resident where able.

An improvement is required to advance directives.

**Criterion 1.1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Advance directives are completed by the resident where able. Where residents are deemed incompetent a medically indicated decision may be made by the GP in discussion with the family/EPOA

**Finding Statement**

Advanced directives/ resuscitation policy is implemented in five of eight resident files reviewed (two mental health and six psychogeriatric) . One psychogeriatric and two mental health residents advance directives did not evidence discussion with the family/EPOA.

**Corrective Action Required:**

Evidence of family/EPOA discussion is provided to validate the resuscitation status.

**Timeframe:**

6 months

**Criterion 1.1.10.8 The service has processes that give effect to consumers' requests on the storage, return or disposal of body parts, tissues, and bodily substances, taking into account the cultural practices of Māori and other cultures.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.9 Where a service stores or uses body parts and/or bodily substances, there are processes and policies in place that meet Right 7(10) of the Code.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

An independent advocate visits weekly on a Tuesday and their contact details are listed within the Introduction Pack. The Life History booklet is a useful tool for staff to orient.

D4.1d; Family are invited to meet with general practitioner after admission and at three monthly reviews (confirmed by the family members interviewed). Following the multi-disciplinary meeting, the care plan is updated. Discussion with seven PG family identifies that the service provides opportunities for the family/EPOA to be involved in decisions

Family option to contribute is then incorporated into the care plan.

Family were seen supporting resident’s e.g. family member of resident (psycho-geriatric) assisting feeding and another family member of resident (psycho-geriatric) assisting mother to hold knitting.

ARC D4.1e, ARHSS D4.1f: The resident file includes information on resident’s family/whine and chosen social networks.

There is one introduction pack shared between resident and family member and there is information on advocacy and consent for mental health residents contained within the Information Pack.

**Criterion 1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🗷 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Two family members were sighted within the main lounges of their family member's resident (psychogeriatric). A private family room is also available for use by residents and their families. Visitors are welcome at any time and sign their names in the visitor’s book at reception. Family members are kept well informed - one family member stated that they are always "kept in the loop" and that when their relative had a fall, the family member was notified that day. One family member is a volunteer reader.

Family members are invited to celebrations on Anzac Day, Christmas Day, Mid-Year Ball as well as a variety of clinical meetings.

Family are encouraged to be involved where possible. One family member accompanies the resident to the movies; another family member accompanies the resident to a local Marae.

There are links to Take 5/Te Whare Marama (now rebranded as Mix, Lower Hutt). Residents have regular outings, as appropriate, as part of the activity programme. These may include, drives, shopping, group entertainment, visits to a neighbouring facility. Various community groups provide regular entertainment. A small number of residents have overnight or short stays with families. Residents with out of town families maintain regular telephone contact. A hairdresser visits weekly and a small number of residents visit the local library.

D3.1.e Discussion with five caregivers and five registered nurses and eight relatives indicates that they are supported and encouraged to remain involved in the community and external groups. Two family members were seen taking their family member out for a walk and one other came to take their family member out for a drive.

**Criterion 1.1.12.1 Consumers have access to visitors of their choice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

The right of the consumer to make a complaint is understood, respected, and upheld.

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

D13.3h. An admission agreement provided to relatives on admission of their family member contains a Complaints Procedure clearly outlining a variety of methods including: anonymous in writing, through the residents' advocate etc. There is a simple Compliment/Concern/Complaint Form within the introductory folder.

A family member said that a complaint would be taken seriously. Seven of seven family members state that they had not ever had cause to make a complaint. One family member stated that they did not think they would need to complain as issues are addressed and never get to a stage requiring a complaint.

The service has complaints management policies and procedures in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack.

Staff are aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family/whanau. Residents and family confirm they are aware of the complaints process and they would make a complaint to the manager if necessary. There is a complaints register in place.

A complaints and compliments folder is maintained with all documentation including acknowledgement letters, investigation reports and follow up letters. These demonstrate that complaints are actively managed in accordance with Manor Park Private Hospital policy.

D3.1.d Discussion with eight of eight family identifies that the service actively involves them in decisions that affect their relatives lives. Two residents interviewed also confirmed that they are informed of the complaints process and included in all decisions that affect their lives.

ARHSS D13.3g: The complaints procedure is provided to relatives on admission.

Two complaints received in 2012 were reviewed and all were dealt with promptly with evidence that there was satisfactory resolution as stated in emails from the complainant. The review indicated that the complaints are actively managed in accordance with Manor Park Private Hospital policy.

**Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

**STANDARD 1.2.1 Governance**

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

ARHSS D5.1 The mission statement states that 'the aim of Manor Park Private Hospital is to provide the highest standard of personal and individual care to each resident and to maintain the dignity and wellbeing of each resident in every respect'. Values are documented including a values statement that is 'we, the staff of Manor Park value life, love, security, shelter, food, comfort, health, dignity, peace, respect, cleanliness, friendship, privacy, empathy, kindness, honesty, integrity, consistency, compassion, humour, tolerance, entertainment, understanding, variety, recognition, approval and consideration…'.

The scope of the service is to provide 24 hour care for each resident of the 54 bed unit that includes three distinct units i.e. Heritage which provides support predominantly for residents who are less mobile, Harris unit which is a 24 bed unit for people who are more mobile and have challenging behaviours and Endeavour unit which is for residents who have less challenging behaviours.

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The owner of the service has a background as a lawyer and provides a support for the manager with meetings on site each one to two days. He also visits on the weekends and takes responsibility for the financial management and has documented the strategic/business plan. Both the owner and manager state that in the future this will be completed by both of them.

The manager is a registered nurse with a current APC (sighted), a Post grad diploma in Paediatric nursing and a Post grad diploma in Perioperative nursing. He has many years’ experience in aged care. The owner confirms that he has confidence in the ability of the manager to provide day to day leadership and operational management.

Staff including caregivers interviewed confirm that the manager is available after hours. The manager interviewed is experienced and understands the management role.

ARHSS D17.5 The manager has maintained at least eight hours annually of professional development activities related to managing a psychogeriatric unit.

**Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The care coordinator provides clinical advice and oversight with team leaders (registered nurses) providing leadership to the teams. The care coordinator is a registered nurse (comprehensive), experience in a level 3 PDRP HVDHB medical ward, current Basic Life Support Certificate DHB and a current APC (sighted). The manager confirms that she is the second in charge with support from the owner to provide operational management.

D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

ARHSS D4.1a: The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and dementia and promotes quality of life.

**Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that there are service operational management strategies and an implemented quality and risk programme which includes culturally appropriate care. The QI/training coordinator facilitates the quality improvement programme.

The service has policies, procedures, processes and systems that support the provision of clinical care and support including care planning and these are reviewed one to two yearly by the manager and clinical team. There is a document control process in place for all policies.

The service has an implemented internal audit schedule and when issues are identified, there is evidence in the monthly quality meeting minutes that these are followed up and issues resolved. A series of regular meetings ensures that all aspects of the quality and risk programme are discussed i.e. infections and infection control, complaints, incidents and accidents, staff, resident issues. These include the following: monthly staff, quality, registered nurse, activity staff, caregiver meetings; two monthly health and safety meetings; household staff meetings as required and two to three monthly and resident/family meetings three times a year (last held in February 2013). The meeting minutes sighted for 2013 indicate that these are held as planned.

There is a preventative maintenance schedule completed annually and this includes documentation of maintenance completed in 2013.

There is a risk management register and hazards documented. A review of these indicates that these are signed off when resolved. A list of current hazards is kept with actions implemented to proactively prevent accidents.

Residents and family complete an annual satisfaction survey with evidence that of the 17 who responded in January 2013, 96% were satisfied. There is an 80-90% satisfaction in all areas of the survey including maintenance of community contact, environment, food, support, comfort and surroundings, accommodation and living space, social, activities, services received.

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management

D19.2g Falls prevention strategies such as use of hip protectors, sensor mats, low beds, increased supervision for identified residents and analysis of falls with strategies implemented as sighted in care plans reviewed. Strategies to manage residents who frequently fall are well described by the registered nurses and caregivers interviewed.

Individual risks are identified in care plans.

ARHSS: D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies. The call bell system is well known to all staff and includes emergency bell sounds to get help immediately and whistles worn by staff and visitors to use if needed. The response as sighted on the day of the audit is immediate when an emergency bell is rung. Staff were also observed to be watching and are extremely vigilant. They respond quickly to any needs even when staff are busy and do not have time to call. Staff work in pairs within teams and are able to describe the importance of working together.

**Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.**

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:**

(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;

(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🗷 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

D19.3b; There is an incident and accident policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

Incidents/accidents are investigated and analysis of incidents trends with graphs documented occurs monthly. There is a discussion of incidents/accidents in monthly staff and quality meetings. These include actions to minimise recurrence. The graphs are also left in the staffroom for staff to view. The caregivers state that they look at the information and discuss in their time as well as through meetings.

Discussions with the owner, manager and the quality improvement/training coordinator confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The manager states that there has been a coroner’s investigation (now signed off) and no other need to contact any authority. The MoH has not been required to be informed of any incidents but the manager and owner state that they are aware that the service has a number of incidents related to the service providing psychogeriatric and mental health services.

There is an open disclosure policy and eight of eight family members interviewed stated they are informed of changes in health status.

There is evidence in the incident reporting folder that there is comprehensive analysis of falls including a 24 hour clock used to identify times of falls and monthly analysis of falls, aggression and all other incidents such as bruising are graphed and reviewed monthly.

Staff on the days of the audit were observed to manage incidents immediately, in a respectful manner and to defuse/de-escalate potential issues. The manager describes staff identifying behavioural issues for new residents with strategies to manage these identified and communicated quickly. This results in new residents settling into the service quickly.

**Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.5 Consumer Participation**

Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Residents participate in service planning through satisfaction surveys that are offered annually. The last survey was completed in January 2013 with 17 returns (predominantly family sent in returns). The residents in the service have varying ability to contribute to planning either by choice or because of persistent and long term mental illness. One resident is able to participate in discussion and in the survey when well and staff describe asking her for input during those times.

Two residents interviewed state that they can have input into the service whenever they like with the manager and owner having an open door policy.

There are three resident/family meetings per year - the last was held in February 2013. Two of two residents state that they are familiar with the meetings and choose to come if they want to.

**Criterion 1.2.5.1 The service demonstrates consumer participation in the planning, implementation, monitoring, and evaluation of service delivery.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.5.2 Consumers and consumer groups involved in planning, implementation, and evaluation of services have clear terms of reference and position descriptions, and are appropriately reimbursed for expenses and/or paid for their time and expertise.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.5.3 The service assists with training and support for consumers and service providers to maximise consumer participation in the service.**

This shall include:

(a) Education and/or training for service providers whose colleagues are consumers working in the service;

(b) Supervision, debriefing, and peer support.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.5.4 The service has policies and procedures related to consumer participation. The policies and procedures are used to maximise consumer involvement in the service and ensures their feedback is sought on the collective view.**

This shall include, but is not limited to:

(a) Employing consumers where practicable;

(b) The service assisting with education, training, and support for consumers to maximise their participation in the service;

(c) Training for service providers in working with consumers as advisors;

(d) Advisors liaising with consumer groups or networks.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.5.5 The service implements processes that involve consumers at all levels of service delivery.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.6 Family/Whānau Participation**

Family/Whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Family members participate in service planning through satisfaction surveys that are offered annually. The last survey was completed in January 2013 with 17 returns. There is an 80-90% satisfaction for all questions including those around maintaining community contact, environment, food, support, comfort and surroundings, accommodation/living area, social, activities and services received. Overall there is a 96% satisfaction recorded.

Family are invited to the MDT meetings throughout the year.

There are three resident/family meetings per year - the last was held in February 2013. Eight of eight family members state that they are familiar with the meetings and choose to come if they want to. They also state that they have a number of opportunities where they can voice their opinions and any plans.

**Criterion 1.2.6.1 The service demonstrates family/whānau and community participation where relevant, in the planning, implementation, monitoring, and evaluation of service delivery.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.6.2 Family/Whānau who participate in an advisory capacity have clear terms of reference.**

This shall include, but is not limited to:

(a) Advice is sought from family/whānau advisory groups when developing terms of reference;

(b) Roles and responsibilities shall be clearly outlined and include accountabilities, confidentiality, and conflicts of interest.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.6.3 The service has policies and procedures related to family/whānau participation. The policies and procedures are used to maximise family/whānau involvement in the service and ensures their feedback is sought on the collective view.**

This shall include, but is not limited to:

(a) Employing family/whānau where practicable;

(b) The service assisting with education, training, and support for families/whānau to maximise their participation in the service;

(c) Training for service providers in working with families/whānau as advisors;

(d) Advisors liaising with family/whānau groups or networks.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Low

There is an in-service education policy. Discussion with the manager, five caregivers, five registered nurses and the diversional therapist confirms that an in-service training programme is in place that covers aspects of care and support. All 16 staff interviewed are able to describe their roles and the caregivers observed during the audit have advanced skills in managing challenging behaviour and in de-escalation. Caregivers supporting residents with mental illness were observed to spend time talking with residents and supporting them to get to activities.

Staff have a comprehensive orientation when they join the service and this includes buddying with other staff. Staff work in teams and pairs to support residents and any new staff are supported to learn how to manage challenging behaviour in supportive and appropriate ways.

There is an education plan 2012 to 2013. The annual training programme exceeds eight hours annually. Trainings in the last year have included models of care, death and grieving, oral health, PDRP training, emergencies, policy of the week (on-going), diabetes and cardiac care, cultural training, infection control, manual handling, pain management, prevention of pressure sores, privacy, code of conduct, health and safety, continence, falls, food safety, diagnosis in psychiatry.

ARHSS D17.1: There are 34 caregivers in the service and 32 have completed the required dementia standards. The activities staff and DT have also completed the dementia standards as have the majority of the registered nurses (13) and enrolled nurses (2). The registered nurse provides mental health leadership and has a master’s degree in mental health. This enables registered nurses to complete care plans using a mental health perspective. Managers and staff talked of the value of the training programme. The two mental health residents state that the staff are appropriate to mental health services and support them to reach goals. Family member’s state that staff are knowledgeable and very skilled at managing what they state are very difficult behaviours.

An improvement is required to dementia training.

**Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

ARHSS D17.1: There are 34 caregivers in the service and 32 have completed the required dementia standards. The activities staff and DT have also completed the dementia standards as have the majority of the registered nurses (13) and enrolled nurses (2). The registered nurse provides mental health leadership and has a master in mental health. This enables registered nurses to complete care plans using a mental health perspective. Managers and staff talked of the value of the training programme.

**Finding Statement**

Two caregivers have not completed dementia training and have been with the service for over six months.

**Corrective Action Required:**

Ensure all staff is enrolled in dementia training within timeframes documented in the ARC contract.

**Timeframe:**

6 months

**STANDARD 1.2.8 Service Provider Availability**

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

A review of eight staff files indicates that there are well implemented HR processes with all staff having a signed contract, current performance appraisals, staff information sheet documented, medication competency if required, evidence of orientation and training records.

There are extra staff allocated when required e.g. for a new resident to support them to settle in or for a resident requiring palliative care.

Since the new ownership, the new manager has extended some shifts (added an extra eight hours a day in total including weekends) and this includes a short shift from 8.30am to 1pm. Another example of a change in shifts is the move to three caregivers doing a 6.45am-3pm shift as opposed to 7am to 3pm. This has added extra staff to support residents with showering, meal times and to organise activities and has helped ensure that staff have a thorough handover in the mornings.

In the afternoons in Endeavour wing, two staff used to start at 2.45pm and two at 5pm. Now there are three staff starting at 2.45pm to 11pm and this supports residents who are sundowning.

The extra staff allows for a staff member to special a resident when needed e.g. for half an hour when Sundowning. Feedback from meeting minutes indicates that staffing levels have been improved and staff can see a difference in resident cares.

Staffing is as follows:

Heritage: AM: three caregivers (two full shifts, one short shift), one registered nurse; PM: two caregivers (two full shifts, one short shift), one registered nurse; night: one caregiver.

Harris: AM: four caregivers (full shifts), one registered nurse; PM: four caregivers (three full shifts, one short shift), one registered nurse; night: one caregiver, one registered nurse who is stationed in Harris but supports all areas.

Endeavour: AM: two caregivers (full shifts), one registered nurse; PM: two caregivers (one full shift, one short shift), one registered nurse; night: one caregiver/enrolled nurse.

Any leave is covered by internal staff not bureau and this helps to settle residents as there are known staff.

**Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🗷 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Manor Park Private Hospital has a ‘Library System’ excel data base for all documents. Each month a list of documents due for review is printed out. These documents are distributed to various staff i.e. infection control coordinator, care coordinator, kitchen supervisor, household supervisor for review. Documents are also reviewed at the health and safety and quality meetings. Once policies are reviewed any changes are made by the quality improvement coordinator. Each document has a number and a version number. If a change is made the version number is updated. All policies are signed off by the manager. Updated policies are then distributed to the relevant areas and filed. A master copy of all documents is kept by the quality coordinator. Policies with significant changes are distributed as policy of the week. Staff are also kept informed of changes through memos, at staff meetings etc.

The service retains relevant and appropriate information to identify residents and track records. This includes information gathered, at admission, with the involvement of the family and with residents particularly those identified as mental health. There is sufficient detail in resident files to identify residents' on-going care history and activities.

Resident files are in use that are appropriate to the service. There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information can be accessed in a timely manner.

Entries are legible, include dates and are signed by the relevant support worker, registered nurse or enrolled nurse.

Individual resident files demonstrate service integration (eight of eight reviewed). This includes documentation of early warning signs, relapse plans, goals and interventions for mental health residents.

Medication charts are in a separate folder with medication and this is appropriate to the service.

**Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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.

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. All needs assessment approvals for psychogeriatric care are signed off by the Psychogeriatrician. Approvals for mental health level of care are signed off by the Psychiatrist. Enquiries and potential admissions are screened by the Manager. The service communicates with Hutt Valley Health needs assessors and other appropriate agencies prior to the resident’s admission regarding the care requirements. There is a comprehensive information pack provided to families which includes all relevant aspects of service delivery and associated information such as the H&D Code of Rights, complaints information, advocacy, and admission agreement. The seven family members interviewed, stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Eight resident’s records had signed resident agreements.

**Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.1.5 To facilitate appropriate and timely entry to the service, a system is implemented to prioritise referrals and identify potential risks for each consumer, including considering previous risk management plans.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is a declining entry policy. The service records document the reason for declining entry to residents should this occur and communicates this to residents/family/whānau and the referring agency. The reason for declining would be if the client did not meet the level of care provided at the facility and there were no beds available. There are no entry declined records.

**Criterion 1.3.2.2 When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The eight resident files sampled identified that an assessment was completed within 24 hours. An initial care plan is completed within 48 hours. Information gathered on admission from Hutt Valley DHB needs assessment, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes and staff progress notes and discussion with family/whanau provide the basis for the initial care plan.

All eight files sampled identify that the long term coordinated care plan is completed within three weeks of admission. There is documented evidence the coordinated care plans are reviewed by a registered nurse and amended when current health changes. All eight coordinated care plans evidenced evaluations completed at least six monthly with three monthly multidisciplinary reviews.

D16.5e: Eight of eight resident files sampled identified that the GP had seen the resident within two working days. It was noted in the resident files sampled that the GP has assessed the resident and recorded their health as stable and to be seen three monthly. More frequent medical review was evidenced occurring in files of residents with more complex conditions or acute changes to health status.

The GP (interviewed) is contracted to visit the home twice a week and spends a full morning conducting routine three monthly reviews and meeting with families to discuss any active problems. Medications are reviewed three monthly. The GP consults with the psychogeriatrician who visits fortnightly for any resident concerns she has. If there is no advance directive resuscitation status this is discussed with the family at the visit. The GP is readily available on her mobile after hours and she states the Care Coordinator or RN notify her promptly of any concerns. The GP visits for an hour on Friday's before the weekend. The two GP's in the practice provide cover for each other's leave. The GP describes a good working relationship with the management and staff at Manor Park.

A range of assessment tools is completed on admission as applicable including (but not limited to); a) Falls risk assessment tool b) Norton pressure area risk assessment, c) continence assessment and management plan d) nutritional plan, f) pain assessment g) wound assessment and h) behaviour assessment. Clinical staff have undertaken education and training in all areas of clinical care such as pressure area care, wound care, continence, dementia care, challenging behaviour, palliative care. RNs interviewed (five) and caregivers (five) described a written handover sheet and verbal report with the oncoming shift (observed). Progress notes are written each shift and are dated, timed with designation.

Tracer methodology:

***XXXXXX This information has been deleted as it is specific to the health care of a resident****.*

Tracer methodology:

***XXXXXX This information has been deleted as it is specific to the health care of a resident.***

**Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.5 The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.6 The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.**

This shall include, but is not limited to:

(a) Consumer support group referrals;

(b) Education programmes;

(c) Consultation and liaison with community groups or relevant self-help groups.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

A comprehensive initial nursing assessment is completed within 24 hours of admission. All available information including needs assessment, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, staff progress notes, discussion with family/whanau is gathered to provide the basis for the initial care plan. The coordinated care plan is completed within three weeks of admission. The two mental health residents interviewed state they had the opportunity to participate in the development of their coordinated care plan. The coordinated care plan includes the nursing diagnosis and problem, early warning signs and symptoms, goals and interventions with on-going evaluations against the goals.

A range of assessment tools is completed on admission as applicable including (but not limited to); a) Falls risk assessment tool, b) Norton pressure area risk assessment, c) continence assessment and management plan, d) nutritional plan, f) pain assessment, g) wound assessment, and h) behaviour assessment. One of two mental health resident files sampled did not have a pain assessment in place for pain management following a post-operative procedure. Families interviewed (one mental health and six psychogeriatric) confirm the assessments are conducted in an appropriate and private manner. Families are asked to assist with the Lifestyle history. Activity assessments are completed by the activities person. Where appropriate a physiotherapy assessment is conducted on admission. Assessment process and the outcomes are communicated to staff at shift handovers.

An improvement is required to ensure a pain assessment is in place where pain is identified.

**Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Pain assessments are required for new episodes of pain.

**Finding Statement**

One of two mental health resident files sampled did not have a pain assessment in place for pain management following a post-operative procedure.

**Corrective Action Required:**

Ensure pain assessments are completed for new episodes of pain.

**Timeframe:**

3 months

**Criterion 1.3.4.5 Where appropriate, cultural assessments are facilitated in collaboration with tohunga or traditional healers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The long term coordinated care plan is developed within three weeks of admission. The front page of the coordinated care plan details the following as relevant to the resident: GP, Pharmacist, advocate, psychologist, psychogeriatrician, cultural support, welfare guardian, EPOA, medical diagnosis, primary RN, key worker, associate caregivers, activities coordinator, physiotherapist, occupational therapist, social worker, chef, podiatrist, consent signed by legal representative and family/whanau goals signed by the family or resident (if appropriate) . There are coordinated care plans for skin, pain, physical health/medical conditions, cultural and spiritual, social interaction and diversional therapy. The resident file contains a red page titled Alerts - Warnings and lists serious medical conditions, adverse/allergic drug reactions and other risks as sighted: suicidal/self-harm, unpredictable, aggressive, or violent behaviour, absconding and resistant to cares. Identified behavioural risks have details including early warning signs and symptoms documented in the coordinated care plan. A behaviour recording chart is maintained for any events and a behaviour analysis is reviewed by the GP every three months or earlier if necessary.

Short term care plans are utilised for short term or acute events. Short term care plans in use are for skin irritation, swollen ankles, painful feet, rash, upper respiratory infection, congestive heart failure, eye infection, ankle wound,

Residents' files include; admission details and information including next of kin details, initial assessment, daily progress notes, elimination chart, BP and weight recordings, short term care plans, long term care plans, risk assessments/nutrition, consents and resuscitation status, MDT review forms, GP visits, laboratory results, NASC assessment, allied health reports, activities, letters, and referrals. All psychogeriatric resident files sampled (six) identified integration of allied health professionals and a multidisciplinary team approach.

Improvement Note:

The service could better document specific residents under the mental health contract and the allied health professionals involved in their on-going wellness.

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.5.3 Service delivery plans demonstrate service integration.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.5.4 The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/ whānau if appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service provides services for residents requiring psychogeriatric level care of care. Currently there are four residents under the mental health contract. Individualised care plans are completed. Identified behavioural risks have details documented in the coordinated care plan and include early signs and warnings and interventions for de-escalation including diversion with activities. There are quiet rooms and wandering pathways indoors and outdoors that can be safely accessed. Behavioural recording charts are used to monitor significant events. The community mental health team is accessed if required. There is a visiting Nurse Practitioner and geriatrician fortnightly to the facility. When a resident's medical condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. The five caregivers and five RN's interviewed stated that they have all the equipment referred to in long and short term coordinated care plans necessary to provide care, including hoists, electric beds, pressure relieving mattresses, shower chairs, transfer belts, wheelchairs, gloves, aprons and masks.

AD18.3 and 4 Dressing supplies are available and the medication room holds adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment.

Wound assessment charts are in place that describe the location of the wound, type, duration, tracing, size (depth/width) and photo if required, factors that may delay healing, dressings and if swab taken. Short term management plans for wounds or skin tears are used. These record the problem and the resident/family goal with symptoms, nursing instruction or interventions, a review date and evaluation which is dated and signed

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day and night use. Specialist continence advice is available as needed and the RN on duty could describe the referral process.

There is a pain assessment tool used to assess a resident’s type, location, severity of pain, treatment and review. Monitoring of effectiveness is reported in the resident progress notes. (Link 1.3.4.2)

All falls are reported on the resident accident/incident form. Falls risk and mobility assessments are completed on admission. The physiotherapist carries out an assessment, transfer plan and Tinetti balance on referral. Other interventions include hip protectors, walking frames, supervised walking, good fitting shoes, uncluttered rooms, sensor mats and use of ultra-low beds. A caregiver on duty is stationed in the Harris wing lounge at all times until residents are settled into bed at night. This practice has reduced the number of falls that were happening in the evenings.

One resident is under a compulsory inpatient treatment order. As such, she is being seen by a psychiatric registrar monthly and the consultant at least six monthly. They monitor and chart every new resident’s behaviour. This is then reviewed by the specialist –in this instance the psychiatrist who then advises them on the best course of treatment and interventions for them to use. With this resident they developed a plan of care that included scripting, consistency, boundary setting and explanations of consequences for her behaviours. This is quite different from the psychogeriatric residents as it acknowledges her higher level of cognition. The other mental health residents are not here under a compulsory order and are treated separately based on their individual need

**Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.6.3 The consumer receives the least restrictive and intrusive treatment and/or support possible.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.6.5 The consumer receives services which:**

(a) Promote mental health and well-being;

(b) Limit as far as possible the onset of mental illness or mental health issues;

(c) Provide information about mental illness and mental health issues, including prevention of these;

(d) Promote acceptance and inclusion;

(e) Reduce stigma and discrimination.

This shall be achieved by working collaboratively with consumers, family/whānau of choice if appropriate, health, justice and social services, and other community groups.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is a registered diversional therapist and two activities assistants employed to develop and implement the activity programme in consultation with residents (where appropriate) and their families to ensure the individual activity, spiritual, cultural and social needs are met. The activities team are on duty from 8am to 6.30pm daily and includes weekends.

A resident activity assessment and social profile is carried out as soon as possible after admission. The activity plan is reviewed six monthly at the multidisciplinary meetings with resident (where appropriate) and family/whanau participation.

The activities team have adequate resources with recreational rooms and an office which can be utilised by residents who wish to sit and chat or prefer to do an individual activity or craft. Activities are held in each of the units and include: craft, baking, men's group, Tai Chi, music therapy, bingo. bowls, quiz and games, balloon tennis, sensory, evening entertainment. There are two activity assistant volunteers who interact with the residents with reading, puzzles, games and walks. The care staff incorporate activities such as walks and reading with residents into their shift as able. The church music group visit and entertain with sing-a-longs.

Other entertainers visit monthly and include school children. There are frequent van drives with a designated driver and the DT and care staff accompany residents on outings.

The DT has a current first aid certificate. Interhome visits occur. The physiotherapist carries out an assessment with the DT to assess a residents suitability for hydrotherapy in the pool. The pool is a great asset for the home and was observed in use on the day of audit. There are safe walking paths, courtyard and seating within a secure area.

The activity team maintains professional development by attending relevant education offered. The DT has attended the Alzheimer’s conference.

There are separate activities for residents with mental illness which includes access to the community in activities appropriate to their needs.

**Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

All initial care plans were developed by an RN within three weeks of admission and evaluated at least six monthly or if there is a change in health status. There is a three monthly multidisciplinary review which includes the GP, RN, Care Coordinator, activities coordinator and any other relevant health professionals involved in the care of the resident. Family/whanau are invited by letter to attend the three monthly review (sighted in resident files) Family members (one mental health and six psychogeriatric) confirm they are invited to the three monthly reviews and are kept informed of any health changes.

The GP reviews the residents medication at least three monthly or when requested if issues arise or health status changes. Short term management plans are evaluated, resolved or added to the long term coordinated care plan if the problem is on-going. There was documented evidence that coordinated care plan evaluations were up to date in eight of eight resident files sampled. Overall changes in health status are documented and followed up. Care plan reviews are signed as completed by an RN.

**Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.8.4 Evaluation includes the use of a range of outcome measurement tools, and input from a range of stakeholders, including consumers, clinicians, and family/whānau if appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The service facilitates access to other medical and non-medical services. The RN's interviewed (five) are able to readily access other services for advice and resident assessments such as physiotherapist, dietitian, wound care nurse, continence nurse, diabetes nurse, palliative care nurse, speech language therapist. Others specialist services are accessed in consultation with the GP, Nurse Practitioner, Psychogeriatrician or Mental Health team.

Referral forms and documentation are maintained on resident files as sighted: podiatry, physiotherapy, older person and rehabilitation centre, psychiatrist, community occupational therapist, dentist, orthopaedics, wound care specialist and gynaecologist. Families interviewed state they are consulted by the GP and RN if referrals to other services are required and they are offered care options for their relative.

**Criterion 1.3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer**

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record is kept and a copy of which is kept on the resident’s file. There is a DHB transfer to hospital from aged care "yellow envelope" system. Information is copied including EPOA and resuscitation information and any relevant clinical notes. Family are notified and a caregiver accompanies the resident to hospital. Discharge documentation from the DHB sighted for recent discharge back to Manor Park. Progress notes sighted record regular communication made with the ward while the resident was in hospital. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made. The five RN's interviewed were knowledgeable in the transfer process and confirmed family are notified of resident transfers to hospital.

**Criterion 1.3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Moderate

There are policies and procedures that describe medication management that align with accepted guidelines. There is one locked central medication room for the three wings. The three medication trolleys are locked. The contracted supplying pharmacy delivers the medications and collects returns twice weekly. There are adequate pharmaceutical supplies. The pharmacy carries out a controlled drug stocktake with the registered nurse (RN) or enrolled nurse (EN) on duty. Weekly checks in the controlled drug register sighted. The medications are in individual bottles clearly labelled with a pharmacy label. The nightshift RN checks all incoming medications and signs the label. Any discrepancies are fed back to the pharmacy. RN's and EN's only administer medications. Medication competent persons undertake a medication assessment and medication education annually. All eye drops are labelled on opening. The medication fridge temperature is checked weekly and recordings sighted are within the acceptable range. There is an emergency tray available for GP use only. Oxygen and suction is available (checked June-12). Nurse initiated medications are administered however there is no signed GP authority that meets the MOH medication guidelines 2011. There is a requirement to ensure there is a GP standing order in place that meets medication guidelines. There are GP orders for bowel management that includes the use of laxatives dated 2004. There is a requirement to ensure the orders are updated and meet the standing orders guidelines.

There are no self-medicating residents. Families are invited to the three monthly reviews. Any changes made to medications are in consultation with the GP, RN, Psychogeriatrician, family/whanau and resident where applicable. A medication monitoring form is put in place for at least two days when a resident has started a new medication or there has been an increase to a current medication. Any adverse reactions, increased risk factors or other concerns are reported back to the GP. Blood levels are monitored for medications such as lithium or tegretol. 16 medication charts sampled all had photo identification, allergies/adverse reactions, precautions and instructions for crushed medications.

Administration signing sheets for regular and prn medications are correctly signed. Controlled drugs administered are signed by two persons. GP prescribing meets legislative requirements. Five of 16 medication charts did not evidence three monthly reviews.

Improvements are required to standing orders and to general practitioner review of medication charts.

**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.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Moderate

There is requirement for GP standing orders to meet MHO medication guidelines. Medication charts are to be reviewed by the GP three monthly.

**Finding Statement**

i) There are GP orders for bowel management that includes the use of laxatives dated 2004. Nurse initiated medications are administered; however there is no signed GP authority that meets the MOH medication guidelines around standing orders. ii) Five of 16 medication charts did not evidence three monthly reviews.

**Corrective Action Required:**

i) Ensure that standing orders meet MoH medication guidelines. ii) Ensure there are GP reviews of medication charts three monthly.

**Timeframe:**

3 months

**Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.7 Continuity of treatment and support is promoted by ensuring the views of the consumer, their family/whānau of choice where appropriate and other relevant service providers, for example GPs, are considered and documented prior to administration of new medicines and any other medical interventions.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is a qualified cook employed during the week and a weekend cook. The cooks are supported by a morning and afternoon kitchen hand. There is a 4 weekly menu that has been reviewed by the dietician. The cook receives resident’s nutritional requirements including likes, dislikes and dietary requirements such as normal, soft, pureed, gluten free and lactose intolerant.

Any changes to resident requirements are made known to the cook. The meals are delivered to the three unit serveries in hot food trolleys. There is sufficient number of caregivers attending to the residents at meal times. There are nutritional snacks available at all times for staff to access outside of kitchen hours. The RN has a key to the kitchen which is locked after hours.

There is daily hot food temperature monitoring done with the combioven probe. There is daily fridge and freezer temperature monitoring of all fridges in the kitchen and the serveries. All recordings sighted. All perishable foods in fridges are date labelled. There are defined storage, preparing, cooking, serving and dishwashing areas. The kitchen is clean and all food is stored off the floor. All chemicals are locked away. There is one chemical bottle in the Endeavour servery that is unlabelled (link 1.4.1) Ecolab provide the chemicals, safety data sheets, conduct internal audits on the dishwasher, chemicals in use and provide training as required. The kitchen equipment is maintained. Cleaning duties are carried out. The floors are mopped daily and duplexed twice weekly.

Staff are observed wearing hats, aprons and gloves. All kitchen staff have completed food and safety hygiene and chemical safety.

The kitchen is clean and all food is stored off the floor. Cleaning schedules and duties lists are in place. All chemicals are locked away. Ecolab conduct internal audits on the dishwasher, chemicals in use and provide training as required.

Two of two mental health residents state that the food is good.

**Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. Staff interviewed (one maintenance, five RN's and five caregivers were knowledgeable in the health and safety procedures and reporting system for incidents. Chemicals are supplied by Ecolab and stored in a locked shed. Safety data sheets and product use chart is readily accessible.

Chemical safety audits are carried out two monthly. The chemicals for the maintenance of the hydrotherapy pool are in a locked room in the pool room.

Safety data sheets are available for the pool chemicals. Protective wear includes gloves, face shield and respirator. The maintenance person (Health and safety representative) has a paramate certificate in Spa and Pool 2 Juy-13.

Waste management is contracted to collect skip bins which include: general waste, incontinent and contaminated products (doubled bagged ) twice weekly. Interwaste provide approved containers for the safe disposal of sharps and collect on request . All chemical bottles have a manufacturer labels except for one. The cleaner’s trolley was seen unobserved on occasions throughout day one of the audit. One chemical bottle in Endeavour servery did not have a manufacturer label on it.

Improvements are required to labelling of chemicals and to ensuring that the cleaner’s trolley is visible to staff at all times. Noting this was addressed on day of audit.

**Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Waste management is contracted to collect skip bins which include: general waste, incontinent and contaminated products (doubled bagged ) twice weekly. Interwaste provide approved containers for the safe disposal of sharps and collect on request. All chemical bottles have a manufacturer labels except for one.

**Finding Statement**

The cleaner’s trolley was seen unobserved on occasions throughout day one of the audit. One chemical bottle in Endeavour servery did not have a manufacturer label on it. This was addressed on the day of audit.

**Corrective Action Required:**

Ensure that chemicals are labelled correctly and that the cleaner’s trolley is visible to staff at all times.

**Timeframe:**

3 months

**Criterion 1.4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

Manor Park private home is located in a quiet park like setting. The reception area is welcoming. The facility has three wings: Endeavour (14 beds), Heritage (14 beds) and Harris (26 beds) each with secure entry and exit doors which blend in with the décor of the room. The building has a current warrant of fitness that expires 26/2/14. Fire equipment checks are conducted by an external fire safety contractor. There is an equipment store room and adequate linen and product storage throughout the facility. Staff amenities and staff lockers are available. The facility's amenities, fixtures, equipment and furniture are all in good order and appropriate for the groups of residents within each wing. There is sufficient space to allow the residents to freely move around the units. The hallways are wide and have hand rails appropriately placed. There is access to outdoor areas and walking pathways that are safe, secure and well maintained. There is a shaded courtyard area with seating. The maintenance person has a part-time gardener to assist in the maintenance of the large gardens. A resident’s outdoor smoking area is available. There is a designated indoor smoking room with ventilation fan activated on entering the room. The maintenance person has a background in building maintenance and carpentry. Daily maintenance requests are entered into the maintenance notes books held in each area. Contractors are called in as necessary. A monthly maintenance report is forwarded to the QI co-ordinator. A two monthly internal building audit is conducted which includes the checking of hot water temperatures recorded at 42-45 degrees.

The following equipment is available: pressure area resources, shower chairs, platform scales, two hoists, electric beds, Hi-Lo beds and five ultra-low beds, wheelchairs. Equipment electrical checks have been conducted. The two hoists and platform scales are overdue for a functional check.

Improvements are required to checks of equipment. Note - Since the draft report the manager advised that all equipment was serviced and tested

**Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Resident related equipment is to be safe for use .

**Finding Statement**

Two hoists and platform scales are overdue for a functional check.

**Corrective Action Required:**

Ensure the equipment is checked and deemed safe for use. Since the draft report the manager advised that all equipment was serviced and tested

**Timeframe:**

1 month

**Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🞏 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Harris wing has three bedrooms with ensuites and two rooms with a shared ensuite. There are adequate numbers of communal toilets, shower and a safe bathroom area. Endeavour has 13 bedrooms with ensuite and there is one communal shower/toilet/bathroom. Heritage has adequate numbers of communal toilets/showers. All toilet/shower/bathroom areas have appropriately placed handrails. Toilets have engaged/vacant slide signs. Privacy locks are easily opened by staff from the outside if required (observed). There is one shower trolley bathroom available. Non-slip flooring and easy clean surfaces are in the showers and toilet areas throughout the facility. Privacy curtains are in place. RN's (five) and caregivers (five) interviewed described how the residents privacy and dignity is maintained when toileting and carrying out personal hygiene requirements.

**Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

Evaluation methods used: D 🞏 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

All bedrooms are single with the exception of four double rooms. The residents sharing a room are selected carefully and families are consulted and consent obtained. The bedrooms are spacious and allow for easy movement around the room for ambulant residents or for the use of mobility aids including a hoist if required. The bedrooms are personalised with their photos and adornments. The bedrooms have photos on the doors that are recognisable to the resident. Electric beds, hi-lo beds or ultra-low beds are provided as required to meet the resident’s needs. Wardrobes are braced to the walls and the vanities locked for safety. Residents and families are happy with the bedroom space, furnishings and have personalised the bedrooms.

**Criterion 1.4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🞏 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The Endeavour, Heritage and Harris wings have a lounge, dining and recreational areas suitable for groups or individual activity. There are seating nooks placed about the facility. Harris wing has an open plan lounge design with seating appropriately placed into smaller groups. There is a courtyard situated off a smaller lounge for indoor/outdoor walks and activities. There are safe outdoor walking paths. A rummage room with assorted items and memorabilia is situated in Harris wing. There are smaller TV lounges and recreational rooms that can utilised by residents who wish to sit quietly with visitors and chat or prefer to do an individual activity or craft. The facility has a beautifully designed chapel/family/whanau room located within the Endeavour wing. There is a visitor’s tea making facility available.

**Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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 being provided.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The household supervisor oversees the laundry and cleaning services. The laundry operates daily from 7am to 2.30pm with two laundry staff. Staff are observed wearing appropriate protective clothing, disposable aprons and gloves. Goggles are readily available. The laundry is divided into a clean and dirty area. The laundry is well equipped with machines to cope with the linen and personal clothing for the facility. Infectious linen is transported to the laundry in yellow laundry bags for separate wash. There is one main cleaner’s room (locked) where three cleaning trolleys are kept. There is a cleaner on duty responsible for each of the wings. Cleaning equipment (including mops) are colour coded for the areas of use. All bedroom floors are wet and dry mopped daily. There is a carpet cleaning (shampoo and spot clean) weekly schedule. The bedrooms and communal areas are clean and fresh. Ecolab provide the chemicals used, safety data sheets and product use wall charts. There is an oasis chemical dispensing unit for the re-filling of chemical bottles. Ecolab conduct quality control checks on the effectiveness of the use of chemicals for laundry and cleaning processes. Internal audits and cleaning schedules are in place. Laundry and cleaning staff have attended chemical safety training, First Aid and Judy Forrest infection control cleaning and laundry course.

**Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.7 Essential, Emergency, And Security Systems**

Consumers receive an appropriate and timely response during emergency and security situations.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Emergency procedures for fire safety and other emergencies are described in policies. All residential support service staff have first aid certificates. Hazard identification, accident and incident reporting and evacuation and emergency procedures are covered in the health and safety orientation and on-going training completed by all staff. Regular fire drills are undertaken as confirmed by all staff and residents interviewed.

The service has a BBQ and extra blankets available in the event of a power failure. A generator can be accessed.

Battery operated emergency lighting is in place. There are torches available in various areas in the facility and in the civil defence equipment kit.

The service has registered nurse cover on site 24/7. There are also staff on duty each shift who hold a current first aid certificate (renewed every two years). There are stocks of wound care and incontinence supplies.

The pantry holds supplies of food that would support the residents for at least seven days. There is 120 litres of water held in Gerri cans which are checked by the maintenance person bi monthly in addition to water contained in water storage tanks The civil defence kit is checked six monthly

All residents interviewed are familiar with emergency procedures (two of two mental health residents).

The date of the evacuation scheme approved by New Zealand Fire Service is 1/12/2004.

Fire drills and education are conducted at least six monthly. Staff have last had fire training in Jan and April 2013.

**Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.6 The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🞏 SI 🞏 STI 🞏 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The facility has central heating to maintain a warm environment throughout the communal areas and bedrooms. All windows are double glazed. There is ceiling ventilation. All bedrooms and communal areas have at least one external window allowing natural light into the rooms. Bedrooms windows have security stays. Bedrooms have night lighting on dimmers. Residents and families interviewed confirmed the environment is warm and comfortable.

**Criterion 1.4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.8.2 All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS**

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The restraint policy includes comprehensive restraint/enabler procedures. There is a documented definition of restraint and enablers which is congruent with the definition in the standard. Restraint assessments are based on information in the care plan, discussions with residents and on staff observations of residents. There is a restraint register and an enablers register. Restraint training has been provided.

The service regards restraint as a last intervention when all other interventions or calming/defusing strategies have not worked.

All restraints / enablers use is discussed at MDT meetings The restraint co-ordinator (care coordinator) is able to describe her role in restraint management and the policies and procedures around restraint use. She states that any use of restraint would be reviewed three monthly and there are strong consent processes that would be implemented.

There are no restraints and no enablers in the service. These numbers have been maintained for a year. The staff use fall out chairs at times; however residents are able to get out of these.

Challenging behaviour training was last provided to staff in July 2012 with plans to provide staff with training in the next two months.

**Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The infection control programme is well established at Manor Park Private Hospital. The quality and health and safety meeting at which IC is discussed, consists of a cross section of staff and there is external input as required from GPs, Med lab and DHB IC nurse.

The programme was written with input from IC Practitioners/Medical Microbiologist initially. The infection control coordinator (RN) works closely with the staff. Staff including the five registered nurses interviewed state that they are well informed about infection control practises and reporting. They can contact the registered nurse or IC officer if required and concerns can be written in progress notes and the communication book.

There is a job description for the infection control coordinator. Infection rates are collated monthly for the service as part of the surveillance programme.

**Criterion 3.1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The infection control coordinator and key staff describe having access to IPCN College, Regional Public Health, DHB’s including the infection control nurse specialist and Bug Control. The infection control coordinator has received training in infection control and prevention last in 2012 and has received information around components of infection control through information provided by the MoH, DHB and laboratory.

She has access to a GP and the infection control nurse at the DHB to provide expertise if this is required.

The role description for the infection control coordinator states that she is responsible for the implementation of the infection control programme with the support of management and staff.

All laboratory and diagnostic investigations are ordered by the GP or psychiatrist if appropriate for mental health residents who receives information about diagnostic results. When the results indicate a risk of spread of infection or a need for further treatment the GP notifies the service.

**Criterion 3.2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

D 19.2a:The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the IC team, training and education of staff.

Infection control policies include a) definition of infection for surveillance, b) IC programme description, c) standards for IC practice – cleaning, food service, linen service, waste management, d) policy and guidelines for antimicrobial usage, e) standard precautions, f) risk management of blood, g) hand hygiene, h) hand care procedures, i) UTI’s, j) clinical indicators of infection, k) Hep A & B & C, l) Inoculation/ contamination emergency response, m) risk assessment plan, n) accidental needle stick blood exposure, o) TB, p) MRSA, q) documentation of suspected and actual infections, r) isolation, s) disinfection, t) outbreak procedure, u) cleaning, disinfection and sterilisation guidelines, v) single use equipment, w) waste disposal policy, and x) notification of diseases.

Related policies around food services and waste management are documented.

Staff interviewed including caregivers and registered nurses are able to describe good practice as per policy.

**Criterion 3.3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The Manor Park infection control nurse has been a member of the NZNO’s Infection Prevention and Control Nurses College since

2009 and attends ICP regional meeting biannually. Aside from accessing infection control information through various websites the IC nurse/team gets advice from Regional Public health, CCDHB, HVDHB and Bug Control.

Infection prevention and control training is provided by the infection control coordinator who is a registered nurse with infection prevention and control knowledge. Records are kept of attendance and the content of sessions with the last documented training around infection control for staff occurring in 2013.

The staff interviewed including the support workers and registered nurses are very familiar with infection control policy and procedures.

Individual staff also receive information from the GP and mental health service when they take individual residents to the GP and this information is passed to other staff at handover as relevant.

Residents receive information about infections as relevant to their needs and abilities and this is included in the resident planning process.

**Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.4.5 Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Infection control data is collated monthly and reported to the monthly quality and health and safety meetings. The meetings include the monthly IC report.

The IC coordinator reports infection control issues and key indicator information analysis to the team on a month basis.

All infections are documented on the infection monthly register. The surveillance of infection data assists in evaluating compliance with infection control practices.

Quality improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken.

The quality coordinator conducts benchmarking against The Manor Park Private Hospital infection rates from previous years by identifying K.P.I's. Systems in place are appropriate to the size and complexity of the facility

**Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**