

Bizcomm New Zealand Limited - Manor Park Private Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Bizcomm New Zealand Limited

Premises audited: Manor Park Private Hospital

Services audited: Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

Dates of audit: Start date: 6 July 2016 End date: 7 July 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 52

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Manor Park private hospital is privately owned and operated. The service is certified to provide psychogeriatric or hospital (medical) level of care for up to 47 residents and hospital - mental health services for up to seven residents. On the day of the audit, there were 52 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, owner, staff and the general practitioner. Families and the general practitioner commented positively on the care and services provided at Manor Park.

The owner employs a facility manager who is an experienced psychiatric and aged care registered nurse. She is supported by a clinical coordinator/registered nurse and a non-clinical quality and training coordinator.

This certification audit identified an improvement required around staff reference checks and having sufficient InterRAI trained staff. The service has exceeded the required standard around the provision of medical services.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and family are provided with information they need on entry to the service that is regularly updated. Information packs contain relevant information on the services and level of care provided. Interviews with family demonstrated they are provided with adequate information and that communication is open.

Regular resident/family meetings provide feedback and regular communication and involvement. All residents have cultural needs identified where these exist. Open disclosure is practiced and appropriate communication with residents and families is implemented. Residents and family are informed of the complaint process and there are policies and procedures to investigate complaints. The complaints register was sighted and the process to successful resolution tracked.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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A documented values and mission statement focuses on providing the highest standard of personal and individual care to residents and to maintain the dignity and wellbeing of each resident. The owner of the service has a background as a lawyer and provides support for the manager with meetings on site each week. The manager has been in the position for 18 months and is a registered nurse. Senior leaders including a registered nurse with qualifications in mental health support her.

Manor Park private hospital has a quality and risk management system in place that is implemented, monitored and 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.

An orientation and training programme provides staff with relevant information for safe work practice and an in-service education programme that covers mandatory training and relevant aspects of care. There are sufficient staff on duty to meet the needs of the residents.

There are resident and family participation processes in place and for family to have regular input into the service. Families state they are involved and supports for families are in place.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident (if appropriate) and family/whānau input. Coordinated care plans viewed in resident records for psychogeriatric and mental health residents demonstrated service integration and were evaluated at least six monthly. Resident files included notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for administration of medicines and complete annual education and medication competencies. Medication charts are reviewed by the general practitioner or psychogeriatrician at least three monthly.

The activities programme provides activities in each unit that meet the resident's individual abilities and recreational needs. 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 kitchen hands. All resident's nutritional needs are identified and accommodated with alternatives provided. Meals are well presented and homely, and a dietitian has reviewed the menu plans. There are nutritious snacks available 24-hours for the residents as required.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility has a current building warrant of fitness. Procedures are in place for emergencies, laundry use and safe management of waste and hazardous substances. The building is safe and well maintained and appropriately heated and ventilated. Residents' bathrooms, personal space areas, outside and communal areas are suitable for their needs. Chemicals are safely stored. Protective clothing and emergency utilities, food and water supplies are available.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has policies and procedures to appropriately guide staff around the safe use of enablers and restraints. The service had one resident with an enabler. There were no residents with restraints. Staff receive training in restraint minimisation and managing challenging behaviour.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (the clinical coordinator), has attended external training and is responsible for coordinating education and training for staff. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. There have been no outbreaks.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	0	1	0	0	0
Criteria	1	111	1	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff demonstrated knowledge and understanding of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and copies of the Code are given to residents and family. The Code is displayed in poster form and family interviews confirmed their understanding of the Code and know about their rights. Access to interpreters is available if required. The Nationwide Health and Disability Advocacy Service pamphlets are accessible on site. Interviews with family (four relatives of residents at psychogeriatric level of care) and observation of staff interactions with residents demonstrated they are provided with adequate information and that communication is open.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established policies/procedures around informed consent and advanced directives. General consents are signed as part of the admission process and include consent for release of information, outings and photographs. General consent forms (sighted) had been signed by the enduring power of attorney (EPOA). Copies of EPOA, previous advance directives (if known) and general practitioner letters of mental capacity were sighted on the files of six psychogeriatric level of</p>

		<p>care residents. There was documented evidence of GP discussion with the EPOA where the resident was deemed incompetent to make a decision regarding resuscitation status. Relatives/EPOA sign consent/permission to operate a personal spending account for their relative.</p> <p>Eight resident admission agreements (two mental health residents and six psychogeriatric) were sighted and all were signed within the required timeframe.</p> <p>Mental health: Residents are provided with an information pack at entry, which forms part of the admission agreement and includes all consent forms they are asked to sign. Both mental health residents' files had signed informed consent forms filed.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information about the Nationwide Health and Disability Advocacy Service is provided to residents and family during the admission process. Residents and family also receive information relating to the Code, which includes reference to advocacy services. Family confirmed that they were aware of the process of how to access the hospital advocate should they have a need to. Staff and training records confirmed that they have received education relating to advocacy and support for residents and family. Families and residents are supported to access their chosen support networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Family stated that they could visit residents at the hospital at any time. Links within the community, such as access to practise of religious belief and shopping with the activities staff, is encouraged and supported. Community events are encouraged and supported for residents to attend to be active in their communities. Residents have regular outings, as appropriate, as part of the activity programme. These may include drives, group entertainment and visits to a neighbouring facility. Various community groups provide regular entertainment. A small number of residents have overnight or short stays with families.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has complaints management policies and procedures in place and residents and their family/whānau are provided with information on the complaints process on admission through the information pack. The complaints process is in a format that is readily</p>

		<p>understood and accessible to residents/family/whānau. Family members interviewed stated that they knew how to make a complaint if they needed to. Management have an open door policy.</p> <p>Staff interviewed were aware of the complaints process and to whom they should direct complaints.</p> <p>Nine complaints received in 2015 and two complaints to date in 2016 (including one DHB complaint) were reviewed, and all were dealt with promptly with evidence that there was satisfactory resolution, as stated in emails from the complainant. The review of complaints evidenced that complaints had been actively managed in accordance with Manor Park Private Hospital policy and Right 10 of the health and disability Code of Rights. There is a complaints register in place.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Code, and information on advocacy is provided to residents and family at admission and posters are displayed throughout the hospital. All family interviewed confirmed they received an information pack on entry that contains a copy of the Code, and the Nationwide Health and Disability Advocacy services. Family are aware the hospital has a newly appointed volunteer resident/family/whānau advocate. Residential care staff interviewed (seven caregivers across morning and afternoons shifts, the clinical coordinator and one registered nurse (RN)) confirm they clarify rights with residents and family where required.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed were able to describe how to keep residents safe from abuse and neglect. Family say their personal privacy and the privacy of their family member's information and belongings are respected. Family interviewed stated that all staff respect their family member's privacy and support them to be as independent as they are able. Visitors and residents have several areas for privacy.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>Manor Park hospital has links with a local marae nearby and access to a Kaumātua for support and advice to staff, residents and their families. College students and younger schoolchildren provide Kapa Haka.</p> <p>There is a current Māori Health Plan that includes an excellent resource on communication. Māori staff are employed and another staff member also has some knowledge of Te Reo.</p>

		<p>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. Resident files reviewed identified that cultural and/or spiritual values, individual preferences are identified.</p> <p>Family members interviewed state that their family member's cultural and spiritual values are upheld.</p>
<p>Standard 1.1.5: Recognition Of Pacific Values And Beliefs</p> <p>Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff are aware of resident's individual needs, values and beliefs and these were noted in resident's files reviewed. Family reported that staff are responsive to resident's individual needs, values and beliefs and stated that they are supported to access cultural and spiritual activities important to them. The service provides regular independent chaplain access for residents. There is support to attend spiritual gatherings and the service respects different views of spiritual care as part of their wellbeing. The hospital cultural folder includes information on Pacific needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Staff are aware of resident's individual needs, values and beliefs and these were noted in resident files reviewed. Family reported that staff are responsive to resident's individual needs, values and beliefs and stated that they are supported to access cultural and spiritual activities important to them. The service provides regular independent chaplain access and services on and off site for all residents. Support is provided for residents (psychogeriatric and mental health) to attend spiritual gatherings and the service respects different views of spiritual care as part of their wellbeing.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>All staff interviewed were able to describe professional boundaries and how they manage these. Senior staff follow up complaints or allegations that are identified as causing concern. Family financial responsibility is clearly outlined within the introductory/information pack and staff do not have direct access to resident's money. Family interviewed stated that residents are invited, but not pressured into participating in activities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the health and disability services standards. Policies and procedures are well established and reviewed regularly to ensure they reflect current best practice to provide continuity of care. Care planning is holistic and</p>

		<p>integrated and includes a six monthly multi-disciplinary review meeting. Families interviewed spoke positively about the care provided at Manor Park. Staff were observed demonstrating a caring and respectful attitude to the residents. Registered nurses and care staff have access to internal and external education opportunities. Careerforce training is provided by the quality and training manager. Facility and clinical meetings enhance communication between the teams and provided consistency of care. There are contracted allied health professionals involved in the care and management of psychogeriatric and mental health residents.</p> <p>Services are provided at Manor Park that adheres to the Health and Disability Sector Standards. An implemented quality improvement programme includes performance monitoring. All approved service standards are adhered to. There are implemented competencies for caregivers and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Family confirmed communication with staff is open and effective and they are kept informed. Resident's files (six psychogeriatric and two mental health files) evidenced family and residents (where appropriate), were consulted and informed of any untoward event or change in care provision.</p> <p>Staff confirmed their understanding of open disclosure. Any communication with family was documented in the resident's progress notes.</p> <p>Family have the opportunity to raise any issues/suggestions they may have and kept informed with matters relating to the facility. Interpreter services were identified internally and externally.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Manor Park Private Hospital is privately owned. The service provides care for up to 54 residents. There are 47 designated beds for psychogeriatric level of care residents and 7 designated hospital level mental health beds. On the day of audit, there were 45 psychogeriatric residents (under the ARHSS contract), 1 younger person (under 65 years) at psychogeriatric level of care and 6 mental health residents under the mental health contract. There were no residents receiving the</p>

		<p>hospital (medical) level of care at the time of the audit.</p> <p>The owner of the service provides support for the facility manager with meetings on site every one to two days. He also takes responsibility for financial management, and has documented the strategic/business plan. The 2016 strategic plan contains the mission and the goals and objectives for the service. The facility manager is a registered nurse with a current annual practicing certificate (APC) and has been at the service for 18 months. She has many years' clinical and management experience in mental health and aged care services and has completed eight hours of professional development relating to the role including an eight hour seminar on DHB contracts, health and safety, complaints management and employment law.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence of the manager, the clinical coordinator (RN) for the organisation undertakes the role of manager. She has 11 years aged care experience and holds a current professional development recognition portfolio. The quality improvement and training coordinator (non-clinical) also supports the care coordinator as required.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The quality and risk management system continues to be implemented at Manor Park Hospital. Interviews with caregivers confirmed that quality data is discussed at monthly staff meetings. There is also a monthly combined quality improvement/health and safety/infection control meeting where all quality data and indicators are discussed. Minutes of these meetings are available to all staff.</p> <p>There is a comprehensive quality improvement plan 2015-2016.</p> <p>There are policies and procedures appropriate for service delivery. Policy manuals are reviewed yearly. Manor Park Private Hospital has a 'Library System' excel database for all documents. Documents due for review are distributed to various staff for review and also reviewed at the combined quality improvement/health and safety/infection control meeting. Policies with significant changes are distributed as policy of the week. Staff are kept informed of changes through memos, at staff meetings.</p> <p>The service collects internal monitoring data (internal audits) with the audit schedule being implemented by the quality improvement and</p>

		<p>training coordinator. Quality improvement data such as incidents/accidents, hazards, internal audit and infections are collected and analysed/evaluated at the combined quality improvement/health and safety/infection control meeting. Corrective action plans have been developed for incident reports. The service has an implemented internal audit schedule and when issues are identified, there is evidence in the combined quality improvement/health and safety/infection control meeting minutes that these are followed up and issues resolved.</p> <p>There is implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has achieved the tertiary level of the workplace safer management practices. Falls prevention strategies are in place that includes the analysis of falls and the identification of interventions on a case-by-case basis to minimise future falls. The facility manager has overall responsibility for health and safety (H&S). There is an H&S representative for each unit and they are part of the monthly combined quality, infections control and health and safety meeting. The representatives are scheduled to attend an H&S training course at the end of July 2016. There is a current hazard register.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Accident/incident data is collected monthly and compared with clinical indicators. Twelve incident forms sampled evidence detailed investigations and corrective action plans following incidents. An incident form sampled where there had been a laceration from a fall, had been followed up with a short-term care plan.</p> <p>Monthly data is taken to the combined quality improvement meeting. The caregivers and the registered nurses interviewed could describe the process for management and reporting of incidents and accidents.</p> <p>Discussions with the manager and clinical coordinator confirm an awareness of the requirement to notify relevant authorities (DHB or MOH) in relation to essential notifications. There have been two Section 31 notifications and one report to Worksafe.</p>
<p>Standard 1.2.5: Consumer Participation</p> <p>Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are</p>	<p>FA</p>	<p>The services family/consumer participation policy outlines active ways to promote and support involvement of residents in the hospital. There is a newly appointed hospital advocate in a voluntary position with a long history of involvement in the hospital. The hospital advocate is well</p>

<p>responsive to the needs of individuals.</p>		<p>known to the residents and has lunch with them twice weekly at the hospital.</p> <p>The hospital advocate will represent and provide input on behalf of residents and family/whānau by attending QI meetings and other regular meetings with management.</p> <p>The hospital advocate will attend resident, family/whānau bi-monthly groups and is available at the hospital twice weekly to provide direct input into areas of interest and concern. Interviews and survey questionnaire responses indicate resident satisfaction with the opportunities to give feedback (through family). The hospital advocate is a part time voluntary position with a position description and access to reimbursement of expenses.</p>
<p>Standard 1.2.6: Family/Whānau Participation</p> <p>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.</p>	<p>FA</p>	<p>Family members participate in service planning through annual satisfaction surveys. The last survey was in March 2016. The service has a consumer family/whānau policy and a family representative. The representative has a position description, with access to reimbursement for expenses and holds the title of hospital advocate. The hospital advocate is available at the service twice weekly or by phone. The hospital advocate interviewed stated that they contribute to service direction and delivery through direct report to the manager and attendance and input into quality improvement meetings and resident/family groups. Family interview stated that staff have good links with them, keep them informed and have found the service has met their expectations. All family stated the staff are friendly, approachable and communicative. There are regular family gatherings for family members to provide feedback to the service and staff. Family are invited and participation is encouraged during admission and reviews of resident care plans.</p> <p>Family are invited to the MDT meetings throughout the year.</p> <p>There are three resident/family meetings per year. Family interviewed stated that they are familiar with the meetings and choose to come if they wish. They also disclosed that they have a number of opportunities where they can voice their opinions and any plans.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>PA Low</p>	<p>Nine staff files were reviewed (including the cook, diversional therapist,</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>a housekeeper, the clinical coordinator, three caregivers and two registered nurses) and included current performance appraisals for those who had been at the service over one year. Current practicing certificates were sighted. Reference checks had been completed in two staff files reviewed.</p> <p>The service has an internal training programme that covers all areas of care and support and exceeds eight hours annually. Staff have specific training around mental illnesses, dementia, managing challenging behaviours, code of rights/advocacy, and behaviour monitoring. The training supports registered nurses to complete care plans using a mental health perspective.</p> <p>Staff have a comprehensive orientation when they join the service and this includes buddying with another staff member. New staff are supported to learn how to manage challenging behaviour in supportive and appropriate ways. Manor Park is represented on a number of postgraduate panels and committees and supports the placement of student nurses. Manor Park has initiated a student handbook that is sent to students prior to their placement. The quality improvement project is yet to be evaluated.</p> <p>Managers and staff talked of the value of the training programme. Family members state that staff are knowledgeable and very skilled at managing what they think are very difficult behaviours.</p> <p>All 22 caregivers in the service have either completed (12 caregivers), or are in process of completing (10 caregivers) Careerforce core training. Those who have not completed the standards have not yet been at the service for 12 months. The RNs also complete the Careerforce dementia standards. The quality co-ordinator and training person is the verifier for Career Force and the DT is the assessor.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Staffing rosters were sighted and there is adequate staff on duty in each area to match the needs of the residents. There are extra staff allocated when required. There is a registered nurse on duty 24 hours per day. The facility manager and care coordinator are registered nurses who work full time.</p> <p>The caregiver workforce is stable. The service is currently recruiting for two RN vacancies. The caregivers and registered nurses interviewed</p>

		<p>stated that there is adequate staffing to manage their workload on any shift.</p> <p>On the morning shift, the clinical coordinator, the facility manager is available to assist as required.</p> <p>Heritage wing: Morning shift - three caregivers, one registered nurse; afternoon shift - three caregivers, one registered nurse; night shift: one caregiver.</p> <p>Harris wing: morning shift - three caregivers, one registered nurse; afternoon shift - three caregivers, one registered nurse; night shift: one caregiver, one registered nurse who is stationed in Harris and supports all areas.</p> <p>Endeavour wing: morning shift - two caregivers, one registered nurse; afternoon shift - two caregivers, one registered nurse; night shift - one caregiver/enrolled nurse.</p> <p>Internal staff covers any leave. There is a casual pool of staff available. Bureau staff are not used as residents are more settled with staff that are known.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>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' ongoing care history and activities.</p> <p>Resident files in use 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.</p> <p>Entries are legible, include dates and are signed by the relevant support worker, registered nurse or enrolled nurse.</p> <p>Individual resident files demonstrate service integration. This includes documentation of early warning signs, relapse plans, goals and interventions for mental health residents.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Psychogeriatric and mental health residents: Residents entry into the service is facilitated in a competent, equitable, timely and respectful manner. Approval for entry has been authorised by the assessment agency and psychogeriatrician. Pre-admission information packs are provided for families and residents prior to or on admission. The service has a comprehensive information folder for residents/families/whānau at entry. Eight admission agreements (for six psychogeriatric residents and two mental health residents) reviewed align with all contractual requirements. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Psychogeriatric and mental health residents: Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Psychogeriatric and mental health residents: The medicine management system meets legislative requirements. Registered nurses and enrolled nurses are responsible for the administration of medication and complete annual medication competencies. Registered nurses have completed syringe driver training. The nurse practitioner for mental health and through the journal club provides annual medication education. The RN checks monthly medications received against the medication chart and any discrepancies are fed back to the supplying pharmacy. The pharmacist is contracted for four hours a week and reviews resident medications. The psychogeriatrician reviews psychotropic medications. Residents are deemed not competent to self-medicate.</p> <p>Standing orders have been reviewed annually by the GPs. Medications are stored correctly and safely. Expiry dates checked weekly. The medication fridge temperatures are within the acceptable range.</p> <p>Sixteen medication charts reviewed (4 mental health and 12 psychogeriatric) included photo identification and allergies. As required medications had indications for use documented. All medication charts sampled showed evidence of being reviewed by the GP and/or the</p>

		psychogeriatrician at least three monthly. Administration signing sheets reviewed corresponded with the medication charts.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Psychogeriatric and mental health residents: There is a qualified cook employed during the week, a weekend cook and kitchenhands. All kitchen staff have completed food safety training. The dietitian has reviewed a four weekly menu. The cook receives a nutritional assessment when resident needs change that includes dietary needs, special/modified diets and resident preferences. These are catered to. One of the units meals are delivered in a hot food trolley with the other two units meals being served in the main dining room. There are a sufficient number of caregivers attending to residents at meal times (observed). Special lip plates and utensils are available for residents to help promote independence with meals. Snacks are available 24 hours per day.</p> <p>Fridge and freezer temperatures are recorded daily. There is daily hot food temperature monitoring using the combi oven probe. All perishable foods in the fridge are date labelled. There is defined storage, preparing, cooking, serving and dishwashing areas. The kitchen was clean and all food is stored off the floor. Kitchen equipment is maintained. Cleaning duties are carried out. Staff were observed wearing hats, aprons and gloves.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	<p>Psychogeriatric and mental health residents: There is an admission information policy. The reasons for declining entry would be if the service were unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Psychogeriatric and mental health residents: The RN completes an initial assessment on admission including risk assessment tools. An InterRAI assessment is undertaken within 21 days of admission and six monthly, or earlier due to health changes. Individual resident needs and supports (including personal preferences and choice), are identified through the ongoing assessment process in consultation with significant others (link 1.3.5.2). InterRAI assessments, assessment notes and summary were in place for all resident files sampled.</p>

		Mental health files reviewed contained appropriate assessment including a life history, an initial assessment and comprehensive information from the DHB.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Psychogeriatric residents: The long-term care plan reflects the outcome of assessments (link 1.2.7.5) and documents the required supports and interventions required to meet the individual needs and goals. The coordinated care plan is resident focused and evidences family participation (as recorded on the family involvement form). All psychogeriatric residents' care plans included a comprehensive 24-hour behaviour management plan. The behaviour management plan included early warning signs and symptoms and interventions that included de-escalation techniques and individualised activities. The coordinated care plans evidenced involvement of health professionals in the care and management of residents.</p> <p>Mental health residents: Mental health files reviewed were goal orientated and contained up-to-date coordinated care plans which were comprehensive and covered all the residents' needs including early warning signs. There were relapse plans with goals and interventions in place for mental health residents.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Psychogeriatric and mental health residents: When a resident's health status changes the registered nurse will review the resident and if required refer to the GP or nurse specialist for a consultation. There is documented evidence on the record of a family correspondence page of relative notification when a resident's health status changes. Family members stated that they are notified promptly of any resident health changes and the resident's needs were being met. Short-term care plans are used to document the interventions and management of short-term needs.</p> <p>There are adequate dressing supplies available as required. There was one resident with cellulitis being monitored and one resident with a wound, on the day of audit. There were no pressure injuries. The clinical manager and RN could describe the referral process for a wound nurse specialist if required. Wound assessments and short-term management plans were sighted for the cellulitis and wound.</p> <p>Continence products are available. Resident continence needs are</p>

		<p>documented in the care plan and reflect the outcome of continence assessments as applicable.</p> <p>Resident weights and observations were monitored monthly. Other monitoring forms include (but not limited to) pain monitoring, food and fluid charts, bowel monitoring and weekly behaviour monitoring charts. Weekly behaviour charts are reviewed by the RN at least weekly and care plans updated to reflect appropriate interventions and de-escalation therapies.</p> <p>Mental health files reviewed showed that when a resident's health status changed short-term care plans were used appropriately and the issues were added into the coordinated care plan if they were ongoing.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Psychogeriatric and mental health residents: The service employs a qualified diversional therapist (DT) and two activity officers to provide the seven day a week programme from 8.00am to 6.30pm. The programme differs between the units and is flexible to meet the resident's needs. The DT and activities assistants 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. Church services are held on site.</p> <p>The activities team have adequate resources with recreational rooms and an office that can be utilised by residents who wish to sit and chat or prefer to do an individual activity or craft. The care staff incorporate activities such as walks and reading with residents into their shift as able. Entertainers visit monthly and include schoolchildren. There are frequent van drives with a designated driver and the DT and care staff accompany residents on outings</p> <p>The service has a hydrotherapy pool that is well utilised for one-to-one therapy. Activity plans are individualised and include one-to-one activities. Pet therapy is provided by the homes cats and visiting dogs.</p> <p>There is evidence of individual activities occurring that are meaningful to the resident. The hydrotherapy pool is used daily for individual one-on-one therapy providing relaxation therapy. The volunteer hospital advocate spends two days a week in one-on-one time with residents for hydrotherapy. A review of coordinated activity plans evidenced the use of the hydrotherapy pool at least one to three times a week. One</p>

	<p>relative interviewed was involved in the hydrotherapy activity with their relative, which gave them an opportunity to participate together in a meaningful activity.</p> <p>The DT spends individual one-on-one time cooking in the kitchenette. Residents in the Endeavour unit are not located within the kitchen area where the smells of baking and cooking can increase appetites. The DT has initiated the cooking of weekly lunches within the unit and residents provide suggestions for the lunch menu and participate in the preparation and cooking of lunch.</p> <p>Other meaningful activities include Tai Chi which is taken fortnightly by a contracted instructor from the community. Tai Chi strengthens muscles and improves balance for the prevention of falls.</p> <p>Music therapy has a positive impact on de-escalation of behaviours. The facility has an agreement for the placement of music students for one day a week. A music therapist visits weekly. The team are compiling resident's choice of music onto individual MP3s for those residents who choose to have these.</p> <p>There are ladies and men's outings monthly with trips to places such as the car museum for the men and morning tea at the gardens for the ladies.</p> <p>The service has been successful in meeting the individual recreational preferences for both resident groups.</p> <p>Mental health residents have the opportunity to attend the community programme. There are separate activities for residents with mental illness, which includes access to the community in activities appropriate to their needs.</p> <p>Individual activities for the younger person are identified through the assessment process and incorporate the resident interests such as music, golf and pets.</p> <p>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/whānau participation. Resident meetings are held three monthly.</p>
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<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Psychogeriatric residents: Long-term care plans in five of six psychogeriatric resident files had been evaluated six monthly. One resident had not been at the service long enough for a care plan evaluation. Written evaluations are documented on the care plan and recorded if the goals have been met or not. Multidisciplinary team records are recorded and include input from the keyworker/RN, caregivers, DT, physiotherapist, pharmacist and GP. The relative is invited to attend three monthly GP reviews and six monthly care plan review meetings.</p> <p>Short-term care plans sighted for short-term needs have been reviewed and resolved, or they are transferred to the long-term care plan if the problem is ongoing.</p> <p>Mental health residents: The coordinated care plans in mental health files reviewed, had been evaluated and updated at least six monthly or as required when the resident's health status changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Psychogeriatric and mental health residents: Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p> <p>The service ensures a RN who is familiar with a resident, accompanies that resident to appointments including transfer to hospital (link CI 1.3.3.4).</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The health and safety, and infection control procedures, document safe storage, management and disposal of hazardous substances. Notices sighted in the cleaners locked cupboard on safe use of chemicals and cleaners can describe safe practices. There are health and safety representatives. A hazard register and maintenance plan is in place. Chemicals are limited to those in general household use with any potentially hazardous substances stored in locked cupboards. Protective clothing appropriate to the service risks are available. There were no incorrectly labelled chemicals found. Chemical safety audits</p>

		are carried out two monthly. The chemicals for the maintenance of the hydrotherapy pool are in a locked room in the poolroom.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires 26 February 2017. The facility has three units: Endeavour, Heritage and Harris, each with secure entry and exit doors that blend in with the décor of the room.</p> <p>There is a system for reactive maintenance and a planned maintenance in place, including ongoing refurbishment of bedrooms. All electrical equipment has been tested and tagged. Clinical equipment has been annually serviced and calibrated. Hot water temperatures recorded, are maintained within the recommended safe range.</p> <p>Psychogeriatric and mental health service: The building was observed to be appropriate and suitable for the needs of residents with safe external areas. 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. Family interviewed say all aspects of the facilities are comfortable and suitable for resident's needs.</p> <p>Care staff interviewed state they have all the equipment required to carry out cares as documented in the resident care plans including hi-low beds, sensor mats, showering equipment and pressure injury mattresses and cushions.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of communal toilets, shower and a safe bathroom area. Twenty bedrooms have ensuites. All toilet/shower/bathroom areas have appropriately placed handrails. Toilets have engaged/vacant slide signs. Privacy locks are opened easily by staff from the outside, if required (observed). There is non-slip flooring and easy clean surfaces are in the showers and toilet areas throughout the facility. Privacy curtains are in place. Staff interviewed described how the resident's privacy and dignity is maintained when carrying out personal hygiene requirements.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p>	FA	<p>All personal space and bed areas were observed to be suitable for residents and there is adequate space to safely and easily manoeuvre</p>

<p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>mobility aids or hoists around beds if required.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The three units provide dining and lounge areas with space for visitors. Family stated they regularly visit and the facilities are suitable for this. There are courtyards situated off the lounge areas for indoor/outdoor walks and activities. There are smaller TV lounges and recreational rooms that can be utilised by residents who wish to sit quietly with visitors. The facility has a chapel/family/whānau room located within one of the units and a designated whanau/visitors room. There is a visitor's tea making facility available.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The laundry operates daily with two laundry staff. Staff were 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 from the sluice rooms to the laundry in laundry bags for separate washing.</p> <p>There is one main cleaner's locked room where the cleaning trolleys are kept. There is a cleaner on duty responsible for each of the units. All cleaning equipment is colour coded for the areas of use. The contracted chemical supplier provides the chemicals used, safety datasheets and product use wall charts. There is a chemical dispensing unit for the refilling of chemical bottles. Internal audits and cleaning schedules are in place.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency and evacuation notices are displayed on site. Staff and residents are familiar with emergency procedures with records confirming appropriate training is undertaken. There is one person on duty at all times with a current first aid certificate. Residents use a call button system to contact staff if needed. There are sufficient civil defence supplies including food and water, held in different locations throughout the building. There is a backup generator onsite. Battery operated emergency lighting is in place. There are torches available in various areas in the facility and in the civil defence equipment kit.</p> <p>The date of the evacuation scheme approved by New Zealand Fire</p>

		<p>Service is 1 December 2004. Fire drills are conducted at least six monthly (records sighted for November 2015 and May 2016). Fire equipment was checked November 2015.</p> <p>There is secure entry/exit at the facility main entrance and into all resident areas.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>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. Bedroom windows have security stays. Bedrooms have night lighting on dimmers. Families interviewed confirmed the environment is warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control coordinator is an RN who has been in the role five years and has a job description that defines the responsibility of the role. Infection control data is reported monthly to the quality/health and safety/infection control committee meetings and at the clinical meetings. The combined quality meetings regularly review the infection control programme,</p> <p>Visitors are asked not to visit if they are unwell. Hand sanitisers are appropriately placed throughout the facility. Forty of 45 residents have received the annual influenza vaccine. Staff are offered the influenza vaccine with 68% of staff receiving the vaccine this year.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator attends annual external infection control and prevention education provided by an infection control specialist, including outbreak management (2015) and a study day in May 2016. She also attends the regional infection control sessions held at the DHB. A combined quality/health and safety/infection control committee support the infection control coordinator. The service has access to support or advice, from an infection control specialist at the DHB, a consultant infection-control specialist, laboratory services and public health services. The GPs provide feedback on antibiotic use.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and</p>	FA	<p>There are current policies and procedures in place that have been developed by an infection control specialist and are reviewed regularly.</p>

<p>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.</p>		
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Monthly infection control education is provided for all staff and is delivered by the infection control coordinator. Staff receive infection control education on orientation. All staff complete hand hygiene competencies. Staff complete infection control questionnaires. Resident education occurs as appropriate.</p>
<p>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.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collects information and forwards a monthly infection control report to the combined quality/health and safety/infection control committee. Information obtained through surveillance is used to determine infection control activities and education needs in the facility. Short-term care plans are completed for all infections. Infection control data and relevant information is displayed for staff. Definitions of infections are in place, appropriate to the complexity of service provided. Trends are identified against key performance indicators and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers including definitions. The facility manager is the restraint coordinator. Staff receive training around restraint minimisation and managing challenging behaviours. The service focuses on de-escalation techniques and one-on-one activities to maintain its restraint-free environment. There is one enabler (lap belt on wheelchair) in use. The coordinated care plan details use of the enabler, risks associated with the use of enabler and monitoring requirements. The GP, restraint coordinator and EPOA (which has been enacted by the GP) have signed the consent/assessment. Staff receive training around restraint minimisation and managing challenging</p>

		behaviours.
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	There are appropriate employment policies and procedures in place. All staff files reviewed contained signed job descriptions. Two staff files had completed reference checks.	Seven of nine staff files reviewed did not contain evidence of reference checks.	Ensure all staff files contain appropriate reference checks. 90 days
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.	PA Negligible	The service has commenced using the InterRAI tool. However, the manager reports that difficulty in accessing InterRAI training for staff means that the service has been unable to meet all InterRAI contractual obligations. Two RNs (InterRAI trained) have resigned leaving the clinical coordinator as the only InterRAI trained RN	Two psychogeriatric residents did not have an InterRAI assessment within 21 days of admission and three psychogeriatric residents did not have routine InterRAI assessments completed as part of the six monthly reviews as from 1 January 2016. This is due to the resignation of trained InterRAI assessors, which the provider has taken steps to replace however, the scheduling of training for the new	Ensure that contractual obligations are met around InterRAI. 180 days

		for the facility.	staff, which is beyond the control of the provider, has led to a delay in the carrying out of InterRAI assessments. The service has not been able to meet the contractual requirements around InterRAI assessments.	
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	CI	<p>The service had an opportunity to review the medical services due to GP resignation and established that resident outcomes could be improved by contracting 24-hour availability of GPs. .</p>	<p>In March 2015, the service identified a need for 24-hour GP service to avoid unnecessary admissions to the emergency department and contracted two GPs from a local practice to provide a 24-hour medical service including site visits. A GP is on the roster each weekend. The GPs have experience and qualifications in palliative care. The GP interviewed confirmed holistic care including end of life care was being well provided. The GP goals and objectives (sighted) aligned with the service philosophy of care. The GP contract (sighted) included an agreement that the GPs would be available outside of normal hours. The 24-hour GP service was supported by the DHB. The DHB provide quarterly reports on all facility presentations to the emergency department and admissions to hospital. Residents of RN concerns are seen promptly and treatment commenced. The service holds a stock of emergency medications and antibiotics. The service has been successful in contracting GP services with a GP available for 24- hours. The data from 2015 to July 2016 evidence reduced admissions to hospital and the emergency</p>

			<p>department since the 24-hour GP service was implemented in March 2015. For 2014 – 2015 there were seven admissions for four residents with infections that could have been treated by a GP, preventing admission to the emergency department. From December 2015 to July 2016 there have been zero residents presenting to the emergency department for treatment. The service has been successful in reducing resident admissions and presentations to the emergency department.</p> <p>The GP and RNs interviewed stated the outcome of a 24-hour medical service has been very positive with resident behaviours reduced due to prompt medical intervention for infections. Residents are not being distressed and taken from their environment for medical treatment. Families interviewed were very pleased with the GP service and were being kept well informed regarding GP visits and treatments.</p>
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End of the report.