

Bizcomm New Zealand Limited - Manor Park Private Hospital

Introduction

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

The audit has been conducted by 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

Dates of audit: Start date: 12 January 2018 End date: 12 January 2018

Proposed changes to current services (if any): Addition: The service is also certified to provide Hospital service – geriatric and rest home- dementia level care (amended schedule letter dated 17 January 2018).

Total beds occupied across all premises included in the audit on the first day of the audit: 50



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 and has total bed capacity of 85 beds. The service is currently 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 50 residents.

Manor Park recently completed building a purpose built 31-bed capacity building connected to the current site. This includes a 21-bed hospital (geriatric and medical) unit and a 10-bed secure dementia unit. A partial provisional audit was completed in December 2017, Manor Park is awaiting the NZ Fire Service approval prior to occupancy. The wing was not yet opened at the time of audit.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations of residents, interview with relatives, staff and management.

Required corrective actions from the certification audit around staff reference checks and having sufficient interRAI trained staff have been addressed.

Two out of six improvements required from the partial provisional audit have been addressed. This was related to completion of the secure outdoor area and outdoor furnishing, obtaining the code of building compliance. However, staff training/orientation and fire evacuation plan approval, staff medication competencies, and hot water monitoring have not yet been completed.

This surveillance audit identified further improvement related to daily progress reporting, carpet replacement, equipment calibration, one aspect of medication management and quality improvement programme.

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 the 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 family surveys 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 three years 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 documented, monitored and generates improvements in practice and service delivery. 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

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Service delivery is multidisciplinary. Registered nurses are on duty 24 hours a day, who provide support and guidance for all staff. GP visits are at least twice a week and are available on call as required. A pharmacist is contracted fortnightly for medication reviews and antipsychotic drug reduction. A community mental health team visits at least fortnightly or earlier if required.

Care plans sampled for mental health residents clearly included interventions to minimise the impact of mental illness.

Registered nurses and enrolled nurses are responsible for administration of medicines and complete annual education and medication competencies. Medication charts are reviewed by the general practitioner, pharmacist or psychogeriatrician at least three monthly. Care plans are comprehensive and reviewed at least six monthly or earlier if there are any changes in a resident's medical condition.

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 kitchenhands. All residents' nutritional needs are identified and accommodated with alternatives provided. There are nutritious snacks available 24-hours for the residents as required.

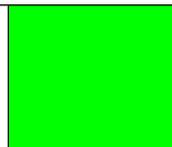
Safe and appropriate environment

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.		Some standards applicable to this service partially attained and of low risk.
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Building warrant of fitness is current. The new building is completed, and Code of compliance has been obtained. Outdoor areas are totally completed, and the dementia unit external area is secure. Outdoor furniture is purchased. Hot water temperatures in the new building are checked and were within safe limits.

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.

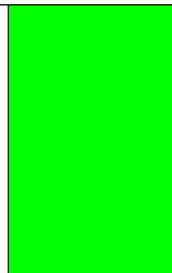


Standards applicable to this service fully attained.

There were no restraints or enablers used on the day of audit. Staff received training around restraint minimisation and managing challenging behaviours.

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 has been an outbreak in November/December 2017 and the ministry of health was notified.

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	13	0	6	0	0	0
Criteria	0	43	0	9	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 1.1.13: 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. 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 understood and accessible to residents/family/whānau. Four family members interviewed (two psychogeriatric and two mental health) 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>There were two complaints (including one HDC complaint) received in 2017 and both were dealt with promptly with evidence that there was satisfactory resolution. The review of complaints showed 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 complaint register in place.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>Family interviewed (two mental health and two psychogeriatric) confirmed communication with staff is open and effective and they are kept informed. Resident's files (five psychogeriatric including one respite care and two mental health files including one aged under 65) evidenced family and residents (where appropriate), were consulted and informed of any untoward event or change in care provision.</p> <p>Staff interviewed (three RNs, four caregivers, one diversional therapist (DT) and one cook) confirmed their</p>

<p>environment conducive to effective communication.</p>		<p>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 are 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 is certified to provide services for up to 85 residents. There are 47 designated beds for psychogeriatric level of care residents and seven designated hospital level mental health beds. On the day of audit, there were 43 psychogeriatric residents (under the ARHSS contract) and seven mental health residents (one receiving respite care) under the mental health contract.</p> <p>There were four residents under the age of 65 (three psychogeriatric level of care and one under mental health contract). There were no residents receiving the hospital (medical) level of care at the time of the audit. Manor Park has completed a new building which has 31 beds (21 hospital beds and a 10-bed dementia unit). This part of the building has not been opened yet.</p> <p>The owner of the service provides support for the facility manager with meetings on-site everyone to two days. He also takes responsibility for financial management and has documented the strategic/business plan. The July 2017 – June 2018 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 three years. 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 1.2.3: 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>	<p>PA Low</p>	<p>There is a comprehensive quality improvement plan 2016 – 2017, currently being reviewed for 2018. There is a monthly quality improvement and three-monthly health and safety/infection control meetings. The clinical coordinator stated that minutes of these meetings are available to all staff. Due to the service being closed for six weeks due to an outbreak of norovirus, no meetings were held in November/December 2017. Review of the meeting minutes showed lack of discussion around quality data. Advised that meeting minutes are displayed in the staff room, so staff can read and sign to confirm their awareness of quality activities at the facility, however there was lack of evidence supporting this practice.</p> <p>There are policies and procedures appropriate for service delivery. Policy manuals are reviewed annually. 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 reviewed at the combined quality improvement meeting.</p>

		<p>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 training coordinator. Quality improvement data such as incidents/accidents, hazards, internal audit and infections are collected and analysed/evaluated. When issues are identified, 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 safety 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 three monthly combined infection control and health and safety meetings. 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>	FA	<p>Accident/incident data is collected monthly and compared with clinical indicators. Ten 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. Monthly data is taken to the quality improvement meeting (link 1.2.3.6). The caregivers and the RNs 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 which were related to pressure injuries.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Eight staff files were reviewed (including the cook, a DT, the clinical coordinator, three caregivers and two RNs). All files had complete employment records including reference checks. Therefore, required corrective action from the previous audit has been addressed. All files included current performance appraisals for those who had been at the service over one year. Current practicing certificates were sighted.</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 RNs to complete care plans using a mental health perspective.</p> <p>The certification audit identified an issue around compliance of interRAI assessment timeframes. This was</p>

		<p>related to lack of interRAI competent RNs and access to interRAI training. Currently there are six interRAI competent RNs to cover 50 residents, therefore this finding has been closed. 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.</p> <p>Managers and staff talked of the value of the training programme. Family member's state that staff are knowledgeable and very skilled at managing what they think are very difficult behaviours.</p> <p>All 27 caregivers in the service have either completed (15 caregivers) or are in process of completing (3 caregivers) or are enrolled in 2018 for 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 coordinator and training person is the verifier for Careerforce and the DT is the assessor.</p> <p>Findings from the partial provisional around employment, orientation and training of new staff for the new building remain open.</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 caregivers and registered nurses interviewed stated that there is adequate staffing to manage their workload on any shift.</p> <p>On the morning shift, the clinical coordinator, and the facility manager are available to assist as required. The night shift has one enrolled nurse, one RN, and two caregivers for the three wings.</p> <p>Heritage wing (14 residents): Morning shift - two caregivers, one registered nurse; afternoon shift - two caregivers, one registered nurse.</p> <p>Harris wing (26 residents): Morning shift – four caregivers, one registered nurse; afternoon shift - three caregivers, one registered nurse.</p> <p>Endeavour wing (14 residents): Morning shift - two caregivers, one registered nurse; afternoon shift - two caregivers, one registered nurse.</p> <p>Internal staff cover 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 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>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>	PA Low	<p>Psychogeriatric and mental health residents: Policies and procedures reflect medication legislation and reference the medicines care guides for residential aged care. Registered nurses and enrolled nurses are responsible for the administration of medication and they have all completed annual medication competencies. Registered nurses have completed syringe driver training.</p> <p>There is a two weekly pre-packed blister medication system. Bulk and stock supplies of medication are stored in the medication room in one of the wings. Medication charts reviewed 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 psychogeriatrician at least three monthly. Administration signing sheets reviewed corresponded with the medication charts. Staff receive training around mental illness and mental health medications.</p> <p>No residents were self-medicating on the day of the audit. A self-medicating resident policy and procedure are available if required.</p> <p>Medication reviews were completed by the GP and a pharmacist. Psychogeriatrician review of psychotropic medications were also sighted in the sampled files.</p> <p>The RN checks monthly medications received against the medication chart and any discrepancies are fed back to the supplying pharmacy.</p> <p>Medications are stored correctly and safely. Expired medications were checked weekly, but some PRN medications did not have an expiry date recorded on the bottle. The medication fridge temperatures are monitored and were within the acceptable range.</p> <p>The finding from the partial provisional audit around medication competencies for the new staff employed for the new building has not been addressed yet.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	FA	<p>Psychogeriatric and mental health residents: Manor Park employs three cooks and three kitchenhands. All kitchen staff have completed food safety training. There is a four-weekly rotating menu which is reviewed by</p>

<p>Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>a dietitian and is due for review in 2018.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the cook. Record of special diets are maintained in the kitchen and special diets being catered for include soft diets, puree diets, gluten free diet, lactose intolerance diet, high protein diet and diabetic diet.</p> <p>Fridge and freezer temperatures are recorded daily. Hot food temperature monitoring occurs. 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>Caregivers were observed assisting residents at meal times. Special lip plates and utensils are available for residents to help promote independence with meals. Snacks are available 24 hours per day.</p> <p>All family members interviewed commented positive about the food services and confirmed that alternative food choices were offered for dislikes.</p>
<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>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. The coordinated care plans evidenced involvement of health professionals in the care and management of 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: Registered nurses are on duty 24 hours a day who provide support and guidance for all staff. GP visits are at least twice a week and available on call as required. The GP expressed confidence that the nursing team provides appropriate and timely referrals and required interventions were being implemented. During the audit visit, staff were seen to respond promptly, professionally and patiently to residents requiring additional or urgent support and guidance.</p> <p>The record of family correspondence form evidenced family notification for changes to resident health status including significant events. Family interviewed confirmed that they were always notified of resident health changes.</p> <p>There is regular specialist input into the treatment and management of residents in the psychogeriatric unit. Strategies for the provisions of a low stimulus environment could be described by the RNs and the DT.</p> <p>There are adequate dressing supplies available as required. The current wounds included skin tears.</p>

		<p>There were no current pressure injuries and one recently healed stage three pressure injury. The clinical coordinator and RNs could describe the referral process for a wound nurse specialist if required. Wound assessments and short-term management plans were sighted for wound care. Pressure injury was reviewed by the wound care specialist.</p> <p>Continence products are available. Resident continence needs are documented in the care plan and reflect the outcome of continence assessments as applicable.</p> <p>Resident weights were monitored monthly, but the scales have not been calibrated (link 1.4.2.1). 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 were updated to reflect appropriate interventions and de-escalation therapies.</p> <p>All 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>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. Care plans sampled for mental health residents clearly included interventions to minimise the impact of mental illness.</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: A team of three diversional therapists (two of those employed as an activities officer), and caregivers were involved in individual activities with the residents. The activities programme is scheduled for seven days a week.</p> <p>A comprehensive social history is completed on or soon after admission and information was gathered from the relatives (and resident as able) and was included in the activity care plan. Activity assessments, activity plan, 24 hours multidisciplinary care plan progress notes and attendance charts were maintained. Resident files reviewed identified that the individual activity plan was reviewed six monthly at the multidisciplinary meetings.</p> <p>Caregivers are observed at various times throughout the day diverting residents from behaviours. The programme observed was appropriate for older and young people with mental health conditions and dementia. Activities were observed to be occurring in the lounges during the audit.</p> <p>Church services are held on-site at the chapel. External entertainers are organised twice monthly. Outings are organised at least three times a week and there is a special lunch offered to residents every Wednesday. The service has a hydrotherapy pool that is well utilised for one-to-one therapy.</p> <p>Music therapy is a big part in the activities programme and is scheduled at least once in the weekly programme. The activities coordinator reported that she plays ukulele, and this occurs instantaneously at</p>

		<p>least three times a week when residents were not interested in other activities.</p> <p>Mental health residents have the opportunity to attend the community programme. There are separate activities for residents with mental illness, which include 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>Family members stated that they were satisfied with the activities provided and staff were involved in activities throughout the day. Family members were welcomed to join activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Psychogeriatric residents: Residents have comprehensive care plans and these plans were consistently evaluated by RNs. Initial care plans were evaluated by the RNs within three weeks of admission. Care plan evaluations reflect changes in care needs or new care plans were developed.</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. The sampled files included; a) wound care management plan for a resident with stage three pressure injury, b) de-escalation techniques were documented in the long-term and short-term care plans as appropriate, c) a resident with infection had up-to-date care planning that describes infection prevention and control techniques, d) a resident with type two diabetes also had a risk management plan around insulin management of type two diabetes and e) neurological observations were completed as required following a fall incident.</p> <p>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>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 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their</p>	PA Low	<p>The new building has been completed but was not open yet. The Code of Compliance had been obtained and hot water checks are based below 45 degrees. The dementia unit outdoor area is secure and outdoor areas are fully completed. These previous partial provisional audit findings have been addressed.</p> <p>The building has a current warrant of fitness which expires on 28 February 2018.</p> <p>This surveillance audit identified two findings around calibration of weighing scale and urine odour on carpets.</p>

purpose.		
<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>	PA Low	<p>On the day of audit, the New Zealand Fire Service was visiting the service to test the new fire evacuation plan. As the fire evacuation plan has not been approved, staff have not completed a fire drill or training around the fire evacuation procedure. Therefore, these two findings from the partial provisional audit remains open.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection control coordinator is an RN who has been in the role six years and has a job description that defines the responsibility of the role. Infection control data is reported monthly to the quality improvement meetings but not at staff meetings or RN meetings (link 1.2.3.6). The quality improvement meetings regularly review the infection control programme and it was reviewed after the norovirus outbreak of November/December 2017. The outbreak commenced 10 November 2017 and affected 21 people, 12 residents and nine staff.</p> <p>Visitors are asked not to visit if they are unwell. Hand sanitisers are appropriately placed throughout the facility. Staff and residents are offered the influenza vaccine.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There were no restraints or enablers used on the day of audit. Staff received training around restraint minimisation and managing challenging behaviours. Auditors observed staff using de-escalation techniques and re-directing residents to a different part of the facility such as outdoor areas and small sitting areas to maintain its restraint-free environment.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality data is collected, analysed and evaluated by the organisation and these are presented at monthly quality improvement meetings. Staff meeting minutes including caregivers and RNs record that a report is tabled by the infection control coordinator but there is no record of the report or the discussion. The minutes of this meeting are planned to be placed in the staff room for staff to read and sign as read. Only one set of minutes from June 2017 were found in the staff room.	There is no documented evidence of discussion of quality data in RN and caregiver staff meeting minutes and lack of evidence of communication of quality data to all staff.	Ensure all quality data is communicated to service providers. 90 days
Criterion 1.2.7.3 The appointment of appropriate service	PA Low	Staff employment for the new building is still in progress. The manager stated that opening of the new building now relies on approval of the proposed evacuation plan by the NZ Fire Service,	Staff employment for the new building has not been completed yet.	Ensure sufficient staff are employed

providers to safely meet the needs of consumers.		therefore opening date for the new building has not been finalised yet.		to provide an effective and safe service in the dementia unit, prior to residents being admitted to the dementia unit. Prior to occupancy days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Completed induction and orientation records were sighted in the sampled staff files. A finding from the partial provisional audit has not been addressed yet. Staff employment for the new building is ongoing and opening date of the new building has not yet been confirmed. Prior to opening, all new staff will complete a two-day orientation which will include health and safety, fire safety training, infection control, medication management, use of medical equipment and supplies, incontinent products, challenging behaviour and manual handling. The registered nurses are scheduled to complete an additional day specific to the required competencies and responsibilities of the role. Competencies such as medication will also be completed at this time.	Orientation for staff is yet to be provided.	Ensure that the planned orientation is completed. Prior to occupancy days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate	PA Low	Fourteen medication charts reviewed (four mental health and ten psychogeriatric) included photo identification and allergies. Observation of medication rounds showed safe and timely delivery of medication. The medication was administered and signed as given according to correct protocol. Medications requiring refrigeration are kept in a medication specific fridge. Controlled drugs are stored safely. All controlled drug register entries follow	PRN medications were dispensed from medication bottles. Expired date of medication was not written on them. Some of the medications were dispensed in 2016.	Ensure that all medications have an expired date written on the medication bottles.

prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		<p>correct procedure and protocol. Medication re-conciliations are completed by the RNs upon resident's return from the public hospital or specialist visits.</p> <p>On interview the RNs stated that medications no longer required or expired are returned to the pharmacy. 'As required' medication in the medicine bottle did not have an expiry date on them.</p>		180 days
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Low	Staff employment for the new building has not been completed yet.	Registered nurses will be employed to manage and administer medications. Advised that medication competencies will be completed during induction and annually.	<p>Ensure that staff who administer medication in the new units have current medicine competencies.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.3.3.3</p> <p>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.</p>	PA Low	All resident files sampled identified that initial assessments and care plans were completed by an RN within 24 hours on entry to the service. The long-term care plan was completed within three weeks of admission in the all long-term resident files sampled. The respite file reviewed had a care plan developed by the community mental health team. All long-term resident's care plans were reviewed by a RN at least six monthly or earlier if there are any health changes. The GP had seen the resident within two working days of admission. It was noted in the resident files sampled that the GP had assessed the resident and recorded their health as stable and to be seen three monthly or more frequent medical reviews were required. There was evidence of mental	Daily notes include a checklist that is completed by the caregivers. This checklist includes residents' physical needs such as shower, skin care, bowel care etc. provided by the caregivers and do not include psychosocial needs. Residents' progress notes reviewed were completed by the caregivers as issues arise, but these have not been	Ensure that progress notes are completed at least once every 24 hours and more frequently as health condition changes.

		<p>health and psychogeriatric team reviews in the sampled files including respite care. The clinical coordinator reports that the mental health team is readily accessible. Review of the files and interview with the manager and the clinical coordinator confirmed that transfer to other facilities and exit from the service was provided in a timely manner and meets residents' needs.</p> <p>Six out of seven files reviewed had up to date interRAI assessments and seventh file was respite care. Caregivers completed a daily checklist and reported on the progress notes. RNs report on the medical notes and all files reviewed had appropriate follow-up by an RN when residents' health condition changes, but in six files (five psychogeriatric and one mental health) residents' progress notes were not always completed daily.</p>	<p>completed daily. The gap of reporting was up to four days including RNs notes in the medical notes.</p>	<p>60 days</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>The building has a current building warrant of fitness that expires 28 February 2018. There is a system for reactive maintenance and planned maintenance in place, including ongoing refurbishment of bedrooms.</p>	<p>1) In two files, resident's weight fluctuated five to three kilograms each month either up or down. On interview, the RNs and the clinical coordinator reported calibration issues of the weighing scale and reported that December and January weighing records were not correct for these two residents. There were no stickers on the scale showing current calibration date. 2) Urine odour on carpets at Harris and Heritage wing were offensive. The manager stated that carpet replacement or hard flooring were scheduled for 2018.</p>	<p>1) Ensure that weighing scale is calibrated. 2) Ensure that urine odour is removed from the carpet or carpet replacement occurs as planned.</p> <p>180 days</p>

<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	<p>PA Low</p>	<p>There are policies related to the emergency and disaster management including fire safety. The new evacuation scheme has not been approved yet therefore staff have not completed a fire drill or training around the fire evacuation procedure.</p>	<p>As the fire evacuation plan has not been approved, staff have not completed a fire drill or training around the fire evacuation procedure.</p>	<p>Ensure that staff receive training related to the new fire evacuation plan.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	<p>PA Low</p>	<p>On the day of audit, the New Zealand Fire Service was visiting the service to test the new fire evacuation plan.</p>	<p>The fire evacuation scheme has not yet been approved by the New Zealand Fire Service.</p>	<p>Provide evidence that the NZFS has approved a fire evacuation scheme for Manor Park.</p> <p>Prior to occupancy days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.