

# Bizcomm New Zealand Limited - Manor Park Private Hospital

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## 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: 9 July 2019 End date: 10 July 2019

**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:** 54

# Executive summary of the audit

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## 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 and 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 54 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, residents, 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 a registered nurse with experience in psychiatric and aged care. She has been in the role five years and is supported by a clinical coordinator and quality improvement/educator/registered nurse, a team of registered nurses and long-serving care and support staff.

This certification audit identified an improvement required around internal audits, consumer and family/whānau survey, timeframes around care plans and interRAI assessments, surveys, and maintenance.

## 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 are provided with information they need on entry to the service and this is regularly updated with input from the consumer/family advocate and other staff during house meetings. Resident/family information packs include specific information such as the Health and Disability Consumer Code of Rights and advocacy services. Interviews with residents and family demonstrated they are provided with adequate information and that communication is open. All residents have cultural needs identified where these exist. Open disclosure is practiced and appropriate communication with residents and families is implemented. Residents/family are informed of the complaint process and there are policies and procedures to investigate complaints.

## 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 medium or high risk and/or unattained 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. Manor Park private hospital has a business plan and quality and risk

management system in place that monitors and generates improvements in practice and service delivery. Key components of the quality management system link to the facility meetings including management, health and safety, clinical and staff meetings.

Resident and family/whānau participation processes are in place. Resident and family/whānau participation are evident through the consumer/family advocate, staff job descriptions and training records. Families said they are involved and supports for families are in place.

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

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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An admission package with information on the services provided at Manor Park is available prior to or on entry to the service.

Registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the general practitioner and visiting allied health professionals. There is a three-monthly general practitioner (GP) review.

Planned activities are provided in each unit that meets 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 resident's nutritional needs are identified on admission and reviewed six monthly or as required. Special diets and dislikes are accommodated. There are nutritious snacks and fluids available 24-hours.

## 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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Manor Park has a current building warrant of fitness. Procedures are in place for emergencies, laundry use and safe management of waste and hazardous substances. Emergency processes are up to date. Protective clothing and emergency food supplies are available. The buildings are appropriately heated and ventilated. Bathroom, personal space areas, outside and communal areas are suitable for resident's needs. Chemicals are safely stored. The processes in place to ensure a safe environment for residents, staff and visitors are appropriate to the service delivery setting. First aid training is provided to staff and is current. Residents are provided with adequate natural light, safe ventilation and heating.

## 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.
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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 quality improvement coordinator/educator), is a registered nurse and 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.

## 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)
<b>Standards</b>	0	44	0	3	1	0	0
<b>Criteria</b>	0	112	0	3	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>Interviews and documentation confirmed Manor Park delivers a service that is focused on the health, wellbeing and cultural needs of its residents. Staff can describe client rights as per the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Copies of the Code are given to all new residents and family/whānau. The Code is displayed in poster form in English and Māori in communal areas.</p> <p>Interviews with two residents (mental health clients) and family/whānau (one of a mental health resident and one of psychogeriatric resident) confirmed they understand the Code and know about their rights. Access to interpreters is available if required. The Nationwide Health and Disability Advocacy Service pamphlets are contained in the information provided and are accessible. Interviews with residents and family/whānau and observations 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</p>	FA	<p>Policies and procedures around informed consent and advanced directives are in place. General consents signed as part of the admission process, include consent for release of information, outings and photographs. General consent forms (sighted) had been signed by the enduring power of attorney (EPOA) or resident as appropriate, or by the consultant.</p> <p>Copies of EPOA and general practitioner letters of mental capacity were sighted in the files of four psychogeriatric level of care residents. One resident had capacity. Two admission agreements were due to be signed as there was no EPOA in place (this is currently going through the court system). Six resident admission agreements were</p>

information they need to make informed choices and give informed consent.		sighted and signed. Resuscitation plans were appropriately signed. Systems are in place to ensure residents, and their family/whānau (where appropriate), are provided with appropriate information to make informed choices and decisions. Discussions with staff confirmed consent is obtained when delivering care. Discussions with family/whānau confirmed that the service actively involves them in decisions that affect their relative's lives.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information about the Nationwide Health and Disability Advocacy Service is displayed in various areas throughout the service. Residents and family/whānau receive pamphlets on advocacy services and information relating to the Code, which included reference to advocacy services on admission. Family confirmed that they were aware of the process of how to access the hospital advocate should they have a need to. Staff stated they had received education (sighted in training records) relating to advocacy and support for residents. The hospital advocate has input into the quality improvement meeting. Family/whānau have access to support groups such as dementia Wellington who provide a series of seminars relating to dementia and the Cog Café monthly meet-up group.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Family said they can visit residents at the hospital at any time. Residents have links in the community with access to practice of religious belief and shopping. Community events are encouraged and supported for residents to attend, to be active in the community. Information packs have clear guidelines for visitors and entry into the premises. Residents talked about regular outings to attend arts and crafts, appointments and shopping. They are assisted to do so by staff as relevant to their health and wellbeing.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and	FA	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 understood and accessible to residents/family/whānau. Family members interviewed stated that they knew how to make a complaint if they needed to. Complaints forms and a suggestions box is available at the main entrance. Management have an open-door policy. Staff interviewed were aware of the complaints process and to whom they should direct complaints.  There were four complaints in 2018 including one complaint to the DHB which was investigated and closed off. Complaints had been acknowledged within the required timeframes and in line with right 10 of the Code.

upheld.		Complaints had been managed appropriately with evidence of a satisfactory resolution. There is a complaints register in place.
Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights.	FA	The Code and information on advocacy services is displayed in the main entrance to the service. Family/whānau confirmed they received an information pack on their family members entry that contains a copy of the Code and the Nationwide Health and Disability Advocacy services. Staff confirmed they clarify rights and advocacy with residents and family/whānau on admission and as required.  Interviews with residents/family confirmed they understand the Code and know about their rights. Access to interpreters is available if required. The Nationwide Health and Disability Advocacy Service pamphlets were accessible. Interviews with residents and family/whānau demonstrated they are provided with adequate information about their rights.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and family/whānau interviewed stated that staff treat them with respect and dignity and support them in their right to be as independent as possible. All staff address them by their given name or preferred name, they knock on the door before entering residents' rooms, they speak to residents in a tone, and manner that is respectful as observed during the audit.  Staff interviewed were able to describe how to keep residents safe from abuse and neglect. Residents and family/whānau said their personal privacy and the privacy of their information and belongings are respected. Visitors and residents have several areas for privacy.
Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their	FA	The organisation has a Māori health plan and cultural policies. Māori cultural needs are identified in the information at referral and staff regularly review cultural needs with Māori residents. The organisation acknowledges the Treaty of Waitangi. Māori staff support residents with support regarding te reo Māori and of the importance of whānau and iwi. The organisation plans to ensure Māori receive services commensurate with their needs. On the day of the audit there were three residents that identified as Māori and staff that identify as Māori. The service has links with a local marae and access to a kaumātua for support and advice to staff, residents and their families. There are links to the Māori health development unit at the DHB for further advice or support as required. The service has a cultural day where college and primary students provide kapa haka. 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. Three Māori resident files reviewed identified that cultural and/or spiritual values and individual preferences

individual and cultural, values and beliefs.		are identified.
<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>The service's cultural policies, procedures and cultural folder include Pacific values, beliefs and links with external Pacific organisations. Cultural needs are identified in the information at referral and on entry. Staff could describe links to Pacific services in the community and stated that they link with these services for further support or interpreting services as required. They also stated that these services would provide education, training, and support to Pacific people or other agencies to promote the well-being of Pacific people. Cultural training for staff is available. Pacific staff are supported and encouraged into positions of leadership and to access funding options for Pacific staff to improve qualifications levels.</p> <p>The resident file of the one Pacific Island resident (psychogeriatric level) identified the residents specific cultural 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 interviewed were aware of resident's individual needs, values and beliefs and these were noted in resident's files reviewed. Family/whānau reported that staff were responsive to their family members cultural needs. They stated that they were supported to access cultural and spiritual activities important to them. Support was provided to attend spiritual gatherings. The service provides regular independent chaplain access and services on and off site for all residents. Staff explained how they acknowledge different views of spirituality as part of the resident's wellbeing.</p> <p>Manor Park has a workforce that represents the cultural composition of the regional area. This allows residents to access staff of their own culture. Family members interviewed stated their family member's cultural and spiritual values are supported by the staff and organisation.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</p>	FA	<p>There are implemented policies and procedures to protect residents from abuse, including discrimination and with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries with residents. Resident rights and family/whānau financial responsibility are outlined in the information packs and staff do not have direct access to resident's money. Staff described the concept of inclusion and non-discrimination. Staff supervisors have had supervision training that includes the identification and maintenance of</p>

harassment, sexual, financial, or other exploitation.		professional boundaries. Family/whānau stated that they felt their family member was safe and that they have not experienced any discrimination, coercion, bullying, sexual harassment or financial exploitation.
Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard.	FA	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. Staff are required to read new/reviewed policies and sign that they have been read. The meeting minutes of facility and clinical meetings are made available to staff and staff confirmed on interview they are kept informed on facility matters and residents' wellbeing. There is a comprehensive education programme including specialist speakers, case reviews and opportunities for external education. There is good liaison with the DHB nurse practitioner for residential care and the older persons mental health practitioners. Care planning is holistic, 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. There are contracted allied health professionals involved in the care and management of psychogeriatric and mental health residents. There are several quality improvement projects being undertaken including improved dental hygiene for residents and sourcing an on-site dental hygienist, end of life (hospice) education for RNs, orientation for enrolled nurses, staff wellbeing, improved pureed meals and reducing falls. The service has researched and implemented a specific falls assessment for psychogeriatric residents that includes the assessment and effect of psychotropic medications. Monitoring the value of using this tool is in progress and includes weekly falls statistics, GP medication reviews, individualised falls prevention strategies, activities, physiotherapy and occupational therapy involvement.
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The service has an open disclosure policy and staff interviewed confirmed their understanding of open disclosure. The service has access to interpreters where required both internally and externally. Residents and family/whānau members confirmed communication with staff is open and effective. Family/whānau said they were kept well informed about the facility and their family/whānau member. Residents/family/whānau have access to an advocate who visits the facility regularly. The manager operates an open-door policy and is readily available to meet with residents/family/whānau. Records of meetings are documented with any outcomes of discussions documented, implemented and signed off.  Residents and/or family/whānau have the opportunity to raise any issues/suggestions they may have and be kept informed with matters relating to the facility. Staff described working collaboratively with residents and family/whānau including mutual open and honest communication.
Standard 1.2.1:	FA	Manor Park Private Hospital is privately owned by one owner/director. The service provides care for up to 54

<p><b>Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>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 47 psychogeriatric residents including three residents under long-term chronic health condition. There were seven mental health residents including four under the mental health act.</p> <p>The owner/director of the service provides support for the facility manager with meetings and regular contact. The owner/director was present at the audit. He also takes responsibility for financial management and has documented the strategic/business plan. The 2019 strategic plan contains the mission, philosophy and objectives for the service. The business plan is reviewed three monthly and annually in consultation with the facility manager.</p> <p>The facility manager is a registered nurse with a current annual practicing certificate (APC) and has been at the service for five years. She has many years' clinical and management experience in mental health and aged care services and is on the advisory team for RN, enrolled nurse and Pacifica nurse training at Whitireia. The facility manager has completed at least eight hours of professional development relating to the role including managing difficult behaviours with an external trainer, interRAI manager training, leadership in aged care and health and safety at work.</p> <p>The facility manager is supported by an operations manager (finances, maintenance and contractors/suppliers) and a clinical coordinator who was appointed April 2019 (previously a senior RN). A quality improvement coordinator/educator is an experienced RN and has been in the role since April 2018.</p>
<p><b>Standard 1.2.2: Service Management</b></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>	<p>FA</p>	<p>During a temporary absence of the manager, the clinical coordinator (RN) undertakes the role of manager. The quality improvement coordinator/educator (registered nurse) also supports the clinical coordinator as required. The owner/director is readily available to the management team.</p>
<p><b>Standard 1.2.3: Quality And Risk Management</b></p>	<p>PA Moderate</p>	<p>The quality and risk management system continues to be implemented at Manor Park Hospital. The service has a quality improvement action plan that is regularly reviewed for progress against identified goals. Interviews with caregivers confirmed that quality data is discussed at monthly staff meetings. There are alternate combined quality</p>

<p><b>Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>improvement meetings and health and safety/infection control meetings where all quality data and indicators are discussed. Minutes of these meetings are available to all staff.</p> <p>There are policies and procedures appropriate for service delivery which are accessible electronically and a hard copy is available to for all staff. Policies are reviewed by the quality improvement coordinator in consultation with the relevant personnel. Old versions of policies are archived electronically. Staff are kept informed of changes through memos and at staff meetings and are required to sign a policy read form.</p> <p>The service completes internal audits as scheduled. Corrective actions identified had not always been followed up and signed off. Two monthly maintenance audits of the facility had repeated findings around two communal toilets in Harris wing (skirting board broken off and walls lifting) that had not been addressed (link 1.4.2.4). Quality improvement data such as incidents/accidents, hazards, infections, concerns/complaints are discussed at staff, quality improvement and clinical meetings, however there is no documented evidence of discussion around audit results and corrective actions.</p> <p>There are no satisfaction surveys completed (link 1.2.5.5).</p> <p>There is implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The facility manager has overall responsibility for health and safety (H&amp;S). There is a health and safety plan for 2018 – 2019 which includes contractor management, medicine management, infection control, staff wellbeing and hazard management. The health and safety (H&amp;S) committee have H&amp;S representatives across each unit and management representatives who meet two-monthly. A H&amp;S representative (operations manager) interviewed had completed a level two H&amp;S course and education on dealing with contractors. The facility manager (health and safety officer) and operations manager attended a due diligence course/update to new legislation. The committee reviews the health and safety plan, accidents/incidents and hazards. There is a current hazard register, reviewed December 2018. All contractors are inducted to the site and are accompanied to the area of work. Contractors sign a register on entry and exit to the facility. All contractors and staff wear a whistle to use for any safety concerns. Volunteers complete an induction as sighted in three volunteer files.</p> <p>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.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically</p>	<p>FA</p>	<p>Accident/incident data is collected monthly and compared with clinical indicators. Twenty-two incident/accident forms (falls, bruises, skin tears and behaviours) reviewed for the month of May 2019 detailed RN review, investigations and corrective action plans following incidents. All incident/accident forms are reviewed by the quality improvement coordinator and signed off by the facility manager.</p> <p>Monthly data is analysed for trends and areas for improvement and reported 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. Neurological observations are completed for unwitnessed falls or where there</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>is an obvious knock to the head and only if tolerated by the resident. Where a resident refuses or becomes agitated during observations this is documented on the incident/accident form.</p> <p>Discussions with the facility manager confirmed an awareness of the requirement to notify relevant authorities (DHB or MOH) in relation to essential notifications. There has been one notification to public health for an influenza outbreak in March 2019. Information has been provided to the coroner at the request of police for a death unrelated to the service.</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 responsive to the needs of individuals.</p>	<p>PA Low</p>	<p>The services family/consumer participation policy outlines active ways to promote and support involvement of residents in the hospital. The advocate visits with residents twice weekly to ensure residents have an opportunity to provide direct input into areas of interest and concern. Residents and family/whānau indicate resident satisfaction with the opportunities to give feedback. The hospital advocate is in a part time voluntary position with a position description. The service has a budget available for the advocate role, and the advocate is being reimbursed for expenses. The service is not implementing annual resident/family/whānau surveys.</p> <p>The hospital advocate represents and provides input on behalf of residents and family/whānau at the quality improvement meetings and other, when requested, regular meetings with management.</p> <p>Staff employed with lived experience have position descriptions, receive training and supervision.</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>The consumer/family participation policy and procedure describes the ways family/whānau can participate. Staff and family/whānau interviewed stated they are encouraged to be involved as much as possible with their family/whānau at an individual level and to attend admission, and reviews of care plans. Family/whānau involvement with decisions relating to policies, protocols, planning, and implementation is through staff with lived experience and input from family/whānau through the facilities manager and the services advocate. Family can also have input by way of verbal feedback to staff, use of letters, phone calls and visits, and the availability of the complaints process. Annual surveys as per the consumer/family/whānau have not been implemented (link 1.2.5.5). Staff interviewed stated that they are aware of the importance of family/whānau involvement in residents' care and actively support this wherever appropriate. Residents and family/whānau interviewed stated that they were comfortable with their level of participation. Staff employed with lived experience have position descriptions and receive training and supervision.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>FA</p>	<p>Eight staff files were reviewed (clinical coordinator, one RN, three caregivers, one diversional therapist, one cook and one cleaner). All files included current performance appraisals for those who had been at the service over one</p>



<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>year. Reference checks and job descriptions were in place in all files reviewed. Current practicing certificates were sighted for qualified staff and allied health practitioners.</p> <p>The quality improvement coordinator/educator coordinates mandatory training days annually that covers two yearly and annual education requirements. The training day is held off-site and includes external speakers. There has been a focus on staff wellbeing with a personal wellness session taken by a personal trainer included in the training day. There are exercise classes for staff, healthy eating education and an employee assistance programme and staff debriefs following incidents. Staff have specific training around mental illnesses (including specific medications), dementia and managing challenging behaviours. Nurse practitioners form the DHB and older persons mental health service provide support and training for staff. They attend the RN journal club meetings for case reviews. Clinical staff have the opportunity to attend external education such as hospice, wound care and DHB clinical study days and older adult mental health study days. The service is linked to the professional development recognition programme.</p> <p>The quality improvement coordinator/educator is a Careerforce assessor. There are 27 caregivers including 14 with level 3 qualifications, two with level 7 mental health and addictions qualifications, eight with level 4 dementia papers and three caregivers (who have been employed less than 18 months) currently progressing through the required Careerforce units. Seven of 13 RNs have completed interRAI training.</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, caregivers and work experience in household areas. The facility manager has developed a memorandum of understanding with ABI rehabilitation 24-hour services (that lease the purpose-built building adjoining the facility) to share education resources.</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. The facility manager, operations manager and quality improvement coordinator/educator work full-time from Monday to Friday. The clinical coordinator works Saturday to Wednesday with Thursday and Friday off.</p> <p>There are at least two RNs on duty morning and afternoon shifts and one RN on night shift.</p> <p>Endeavour wing is 14 beds with four mental health clients and 10 psychogeriatric residents: Morning shift - two caregivers and afternoon shift - two caregivers.</p> <p>Heritage wing is 14 beds with 14 psychogeriatric residents: Morning shift - two caregivers and afternoon shift – two caregivers.</p> <p>Harris wing is 26 beds with three mental health clients and 23 psychogeriatric residents: Morning shift - three caregivers and afternoon shift - two caregivers (one full shift and one finishing at 9 pm with this shift extending</p>

		<p>depending on resident acuity). One registered nurse is stationed in Harris for all shifts and supports all areas on night shift.</p> <p>There are three caregivers and one RN on night shift or two caregivers, one enrolled nurse and an RN.</p> <p>The caregivers and registered nurses interviewed stated that there is adequate staffing to manage their workload on any shift.</p> <p>Internal staff cover any leave. Bureau staff may be used for one-on-one with residents as required. There is a memorandum of understanding with ABI services to access staff for Manor Park shifts as available.</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>	FA	<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 clients. 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 caregiver, 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>	FA	<p>Manor Park potential residents have a needs assessment completed prior to entry. The service has an admission policy, admission agreement and a resident information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of the service. Eight resident files (two mental health residents and six psychogeriatric residents including one under long-term chronic health condition) were reviewed. Two resident's admission agreements were being processed by the court and one resident was admitted under the Mental Health Act. The five Manor Park resident admission agreements viewed were signed. Admission agreements in the files reviewed align with contractual requirements. Exclusions from the service are included in the admission agreement. The facility manager and clinical coordinator described the entry and admission process.</p>
<p>Standard 1.3.10: Transition, Exit,</p>	FA	<p>A transfer document, summary care plan and medication profile are generated when residents are transferring to hospital. All relevant information is documented and communicated to the receiving health provider or service.</p>

<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>Planned exits, discharges or transfers are 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.</p> <p>There was evidence in one of the two Mental Health resident files sampled of intervention from allied health professionals to enable the resident to build skills and strategies to access the community more effectively.</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>There are policies and procedures in place for safe medicine management that meet legislative requirements and guidelines. The facility has one medication room. The medication trolleys are kept in locked rooms.</p> <p>Registered nurses, enrolled nurses or medication competent carers administer medications from blister packs on medication rounds. These staff have been assessed for competency on an annual basis and attend annual medication education. Registered nurses and ENs attend syringe driver education. All medication is checked on delivery against the electronic medication chart. All medications were securely and appropriately stored. There were no residents self-medicating on the day of audit. The medication fridge is maintained within the acceptable temperature range. All eye drops and ointments were dated on opening.</p> <p>Sixteen medication charts reviewed met legislative requirements; all charts had photo identification and allergies/adverse reactions noted, and 'as required' medications prescribed correctly with indications for use. Medications had been signed as administered in line with medication charts. The 16 medication charts included three monthly GP reviews as appropriate. Appropriate practice was demonstrated on the witnessed medication round.</p> <p>The GP, pharmacy, mental health practitioner or psychiatrist and resident/relative as appropriate are involved in medication reviews or the commencement and monitoring of new medications.</p>
<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</p>	<p>FA</p>	<p>Manor Park employs three cooks, morning kitchenhands and afternoon cook/kitchenhands to provide meals for the psychogeriatric residents and mental health clients. The service also provides main meals for residents in the ABI rehabilitation service in the adjoining building. All kitchen staff have completed food safety training. There is a four-weekly rotating menu which has been reviewed by a dietitian. The food control plan was verified 22 May 2019. Meals are served from bain maries in the Harris and Heritage dining rooms and are plated and delivered in a hot box to the Endeavour dining room.</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 (interviewed). Record of special diets are maintained in the</p>

<p>component of service delivery.</p>		<p>kitchen and special diets being catered for include soft diets, puree diets, gluten free and lactose free diet. There are nutritious snacks available 24 hours. The service is focusing on improving the appearance and flavour of puree meals and staff have recently attended relevant training and purchased pureed moulds. Fluids such as Complan, Ensure and thickened fluids are made up daily and readily available. Caregivers were observed assisting residents at mealtimes. Special lip plates and utensils are available for residents to help promote independence with meals.</p> <p>Fridge and freezer temperatures are recorded daily. Hot food temperature monitoring occurs. All perishable foods in the fridge are date labelled. The kitchen was clean, and all food is stored off the floor. Kitchen equipment is maintained. Cleaning duties are carried out.</p> <p>Family members and two mental health residents interviewed commented positively about the food services.</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>	<p>FA</p>	<p>If entry is declined, the facility manager communicates directly with the referring agencies and potential resident or family/whānau as appropriate. The reason for declining entry to the service would be if there were no beds available; or the potential resident did not require the level of care provided at Manor Park; or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>There was evidence in files reviewed that the registered nurse completes an initial admission assessment within 24 hours, which includes relevant risk assessment tools and behaviour assessments for all residents. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident/relative and significant others.</p> <p>InterRAI assessments were completed within 21 days of admission for psychogeriatric residents (link 1.3.3.3). InterRAI assessments, while not required for mental health residents, had been completed by the RNs. Routine interRAI assessments are completed as part of the six-monthly care plan evaluation process.</p> <p>Additional assessments for management of wound care were appropriately completed according to need.</p> <p>The long-term care plans reflected the outcome of the assessments. Cultural assessments had been completed for residents in consultation with family/whānau, kaumātua or significant others and outcomes documented in the care</p>

		plan.
<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>The registered nurse develops the long-term care plan (link 1.3.3.3) from information gathered during the first weeks of admission. The resident care plan has categories of care that include activities of daily living, skin and pressure area care, elimination, mobility, nutrition and fluids, sleep, communication, vision, memory, behaviour and medical needs.</p> <p>The care plans reviewed reflected the outcomes of risk assessments. Interventions clearly described support required. Each resident's file reviewed had risks incorporated into the care plan; resident's medical problems and alerts such as high falls risk and behaviour management plans. There was documented evidence of resident/relative/whānau involvement in the care planning process as was appropriate.</p> <p>Short-term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short-term care plans sighted included management of wounds and behaviour management. There was evidence that short-term care plans reviewed had been evaluated at regular intervals and integrated into the long-term care plan if an ongoing problem.</p> <p>Medical GP notes and allied health professional progress notes were evident in the residents integrated files reviewed.</p> <p>The service delivery plans identified early warning signs. Relapse prevention plans were in place for residents whose files were sighted that had been admitted under the Mental Health Act. In the files sampled there was evidence that the plan had been developed in partnership with the consumer, service provider and family / whanau as appropriate.</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>The registered nurse initiates a review of the resident's care needs when there is a change in the resident's condition and arranges a GP or nurse specialist visit if required. There is evidence of three-monthly medical reviews, or the GP will visit earlier if there is a change in health status. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident's health status. Resident files reviewed recorded communication with family. There is involvement of other health professionals and community groups working in consultation with the resident/family and care staff to support resident's mental health and wellbeing with the least restrictive and intrusive treatment possible.</p> <p>Staff reported there are adequate continence supplies and dressing supplies. On the day of the audit, supplies of these products were sighted.</p> <p>There were five wounds and no pressure injuries being treated on the day of the audit. Wound assessments had been completed for all wounds. There was evidence of GP and wound specialist nurse involvement for two of the</p>

		<p>five wounds. Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.</p> <p>Behaviour management plans are developed with multi-disciplinary input and describe types of behaviour, possible triggers and interventions. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts and behaviour monitoring charts are available for use.</p> <p>Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity and nutrition. Caregivers interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions. The active short-term care plans and long-term care plans were readily accessible in the resident files.</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>The service employs a qualified diversional therapist (DT) and two activity officers to provide the activities programme seven day a week. The programme differs between the three 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>Care staff incorporate activities such as walks and reading with residents into their shift as able. Entertainers visit monthly and include schoolchildren, kapa haka and other cultural activities. 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 and relaxation therapy. Activity plans are individualised and include one-to-one activities. Pet therapy is provided by the homes cats and visiting dogs. There is evidence of individual activities occurring that are meaningful to the resident.</p> <p>The DT spends individual one-on-one time cooking in the kitchenette. 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>Music therapy has a positive impact on de-escalation of behaviours. A music therapist visits weekly. The service has been successful in meeting the individual recreational preferences for both resident groups. 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.</p> <p>Family interviewed stated they felt the activities programme was extensive and individual resident needs and</p>

		abilities were catered for.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term care plans were in place for six of the seven resident files reviewed. One resident had not been at the service long enough to have a long-term care plan developed. Long-term care plans were evaluated six monthly or as required when the resident's health status changed. Written evaluations are documented on the care plan and recorded if the goals have been met or not met. Multidisciplinary team records are documented and include input from the registered nurse, caregivers, diversional therapist, physiotherapist, pharmacist and GP. Relatives are invited to have input into six-monthly care plan review meetings. Short-term care plans had been reviewed and resolved or transferred to the long-term care plan if the problem was ongoing.</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>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. A transfer document, summary care plan and medication profile are generated when residents are transferring to hospital. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and their families are kept informed of the referrals made by the service. The RNs interviewed described the referral process to other medical and non-medical services.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from</p>	FA	<p>Manor Park has processes in place for the management of waste and hazardous substance. These processes are documented, and incidents are reported on in a timely manner. The service uses materials provided by a cleaning product contractor. The contractor provides cleaning products which have emergency processes documented on the labels. Notices were sighted in the cleaners locked cupboard on safe use of chemicals and cleaners (interviewed) described safe practices. Chemicals are limited to those in general household use with any potentially hazardous substances stored in locked cupboards.</p> <p>Staff have received training and education to ensure safe and appropriate handling of waste and hazardous substances. There is provision of protective clothing and equipment that is appropriate to the recognised risks, for</p>

<p>harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>example, aprons, gloves and masks.</p> <p>During a tour of the facility, protective clothing and equipment was observed. The chemicals for the maintenance of the hydrotherapy pool are in a locked room in the poolroom area.</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 purpose.</p>	<p>PA Low</p>	<p>The building has a current building warrant of fitness which expires in February 2020. The building was observed to be appropriate and suitable for the needs of residents with safe and secure external areas. There is a planned maintenance schedule implemented. There is an annual test and tag programme that is current, with checking and calibrating of clinical equipment annually. A bi-monthly maintenance audit check in February identified a skirting board was missing in one of the resident's toilets that had not been repaired/replaced at the time of the audit. Environmental improvements include the recarpeting of two wings and the third is to be completed in the near future.</p> <p>Residents and family/whānau interviewed said all aspects of the facilities were comfortable and suitable for their needs. Hot water temperatures are safe, monitored and recorded monthly. There is safe access to the building with a ramp and steps. There is a visitors' sign-in book. There are quiet areas throughout the facility and gardens for residents and their visitors to meet. There are areas that provide privacy when required. There are also areas with grass and shade, seating and outdoor tables.</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</p>	<p>FA</p>	<p>There are adequate numbers of accessible toilets/showering and bathing facilities. Twenty bedrooms have ensuites. Visitors toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas and other equipment/accessories are made available to promote resident independence. Residents and family/whānau reported there are sufficient toilets and showers. Bathroom facilities sighted are appropriate for use and are clean and private.</p>



requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate personal space provided in bedrooms which allows residents and staff to move around within the room safely. Residents interviewed spoke positively about their rooms. Mobility equipment was sighted in rooms of residents requiring this, with sufficient space for the equipment, staff and the resident.</p> <p>Rooms can be personalised with furnishings, photos and other personal adornments and the service encouraged residents to make the space their own. There is room to store mobility aids such as walkers when 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>	FA	<p>There are three units that provide dining and lounge areas with space for visitors. Family/whānau said 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 whānau/visitor's room. There is also tea making facilities available to family/whānau.</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</p>	FA	<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 cleaners' 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>

provided.		
<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>	FA	<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. There are call bells in resident rooms and communal areas. Residents use a call button system to contact staff if needed. The service uses miracle Care call systems which monitors their alarms and automatically reports any faults via the angel base system which is located in the front office. There are sufficient civil defence supplies including food and water, held in different locations throughout the building. There is a backup generator and four 1500 litre water tanks on site. 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 Service is 25 January 2018. Fire drills are conducted at least six monthly. Fire equipment was checked October 2018.</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>Resident rooms have at least one external opening window of normal proportions and plenty of natural light. Bedroom windows have security stays and night light dimmers. There are heat pumps and additional heaters as required. The home was warm and comfortable on the day of the audit. Residents and family/whānau 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</p>	FA	<p>The infection control coordinator is the quality improvement coordinator/educator and RN who has been in the role 14 months 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 staff and clinical meetings. The combined quality meetings regularly review the infection control programme and the infection control goals in the health and safety plan.</p> <p>Visitors are asked not to visit if they are unwell. Hand sanitisers are appropriately placed throughout the facility.</p>

<p>consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>Residents and staff are offered the influenza vaccine with 72% 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>	<p>FA</p>	<p>The infection control coordinator attends external infection control and prevention education last in May 2019. The infection control committee members (enrolled nurse and caregiver) are scheduled to attend a DHB study day on infection control in October 2019. The combined quality/health and safety/infection control committee meet monthly. The infection control coordinator 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 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</p>	<p>FA</p>	<p>There are current policies and procedures in place that have been developed by an infection control specialist and are reviewed regularly. Policies are available to staff.</p>

practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Infection control education is provided for all staff and is included in the annual mandatory training day. Staff receive infection control education on orientation. All staff complete hand hygiene competencies and infection control questionnaires. Topical education in-services are provided on site and have included multi-resistant organisms and outbreak management. The infection control coordinator coordinates and delivers all education.</p> <p>Resident/family education occurs as appropriate and related to resident conditions.</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>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. Infection control data and relevant information is displayed for staff. Definitions of infections are in place and 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.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p> <p>There has been one influenza outbreak in March 2019 which was well managed affecting 16 residents with 13 residents in one unit. Case logs and public health notification was sighted.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>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 as part of the annual mandatory training day. 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. The PG and LTS-CHC residents reviewed included needs assessments for a secure environments. The two mental health residents reviewed included documentation to reflect they were under the mental health ACT and requiring</p>

		secure environments. There is one other resident who wishes to be there and signed a consent to stay in the secure environment. The resident has code to the doors so they are able to come and go.
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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)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA</p> <p>Moderate</p>	<p>Internal audits are completed as scheduled and cover the clinical areas and medications, infection control, health and safety and building compliance. Eight of sixteen audits did not have corrective actions developed for identified issues. Internal audit outcomes/corrective actions had not been discussed at management or staff level.</p>	<p>There were no corrective actions developed for issues/concerns identified for eight of sixteen internal audits completed for 2019 to date.</p>	<p>Ensure corrective actions are developed, addressed and signed off as completed</p> <p>90 days</p>
<p>Criterion 1.2.5.5</p> <p>The service implements processes that involve consumers at all levels of service delivery.</p>	<p>PA Low</p>	<p>Consumers and family have verbal input into service delivery, through the volunteer advocate and caregivers. Management stated there is an open-door policy for residents and family. The services consumer policy states the service will implement annual satisfaction surveys; however, these are not being completed.</p>	<p>The services family/consumer participation policy states the service will implement annual satisfaction surveys; however,</p>	<p>Ensure annual family/consumer satisfaction surveys are implemented as per policy</p>

			these are not being completed	180 days
<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	<p>Registered nurses are responsible for each stage of provision of care including admissions, initial assessments and development of long-term care plans within required timeframes. Not all long-term care plans had been completed with 21 days of admission. First and routine interRAI assessments are required for psychogeriatric residents, however not all first interRAI assessments had been completed within the first 21 days. These are not required for mental health residents but have been completed by the RNs.</p>	<p>(i) Long-term care plans had not been completed with 21 days for three psychogeriatric residents and one mental health resident.</p> <p>(ii) First interRAI assessments had not been completed for three psychogeriatric residents within 21 days of admission.</p>	<p>(i)-(ii) Ensure long-term care plans and interRAI assessments are developed within the required timeframes.</p> <p>90 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	<p>The February maintenance audit checklist documented that the skirting boards in one of the resident's toilets required repair/replacement. This has not been completed.</p>	<p>During the tour of the facilities it was identified that one of the residences toilets skirting boards required repair.</p>	<p>Ensure all repairs identified are implemented in a timely manner to minimise risk of harm to residents.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.