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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	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: 15 January 2021 End date: 15 January 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 51

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

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 51 residents.

This 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 the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The owner employs a facility manager who is a registered nurse with experience in psychiatric and aged care. She has been in the role six and a half years and is supported by a clinical coordinator, an operations manager, a team of registered nurses and long-serving care and support staff.

The service has an established quality and risk management system. Families and the general practitioner interviewed commented positively on the standard of care and services provided.

Three of the four shortfalls identified as part of the previous audit have been addressed. These were around, follow-up of quality action plans, an annual survey and environmental maintenance. There continues to be an improvement required around time assessment.

This audit included improvements required around; care plan interventions, activity plans and medication management.

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.

Interviews with family demonstrated they are provided with adequate information and that communication is open. 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.		Standards applicable to this service fully attained.

Manor Park private hospital has a documented values and mission statement that focuses on providing the highest standard of personal and individual care to residents and to maintain the dignity and wellbeing of each resident. The service has a current 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, quality/infection control/health and safety, and staff meetings.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

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.		Standards applicable to this service fully attained.

Manor Park has a current building warrant of fitness. 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 residents' needs. Processes are in place to ensure a safe environment for residents, staff and visitors within a secure environment. First aid training is provided to staff and is current.

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.

The service has policies and procedures to appropriately guide staff around the safe use of enablers and restraints. There were no residents with restraints or enablers. Staff receive training in restraint minimisation and managing challenging behaviour.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator 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)
Standards	0	15	0	1	3	0	0
Criteria	0	48	0	1	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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 has an open-door policy. Staff interviewed described the complaints process. The service has had many compliments and two complaints since the previous audit. Complaints had been acknowledged within the required timeframes and in line with right 10 of the Code. Complaints had been managed appropriately with evidence of a satisfactory resolution. There is a complaint register in place.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	The service has an open disclosure policy and staff interviewed (one RN, four caregivers, one facility manager, one operations manager and one cook) confirmed their understanding of open disclosure. The service has access to interpreters where required both internally and externally. Family/whānau members interviewed (three with a family member in the psychogeriatric units (PG) and two with a family member in the mental health unit) confirmed that staff are approachable and easy to communicate with. Family/whānau described that they are 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 facility manager operates an open-door policy and is readily available to meet with residents/family/whānau.

conducive to effective communication.		Family/whānau have the opportunity to raise any issues/suggestions they may have and be kept informed with matters relating to the facility. Staff interviewed talked of the ways they work in partnership with residents and family/whānau including mutual open and honest communication.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The service is privately owned by one owner/director. Manor Park Private Hospital provides care for up to 54 residents. The service has 47 designated beds for psychogeriatric level of care residents and seven designated hospital level mental health beds. On the day of audit, there were 47 psychogeriatric residents including two residents under long-term chronic health condition and one under ACC. There were seven mental health residents including three under the mental health act. The owner/director of the service provides support for the facility manager and operations manager with monthly meetings and regular contact. He also takes responsibility for financial management and has documented the strategic/business plan. The 2020-2021 strategic plan contains the mission, philosophy and objectives for the service. The business plan is reviewed annually in consultation with the facility manager. The Manor Park Private Hospital facility manager is a registered nurse with a current annual practicing certificate (APC) and has been at the service for seven 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. The facility manager is supported by an operations manager (finances, maintenance, HR and contractors/suppliers) and a clinical coordinator who was appointed April 2019 (previously a senior RN). The quality improvement coordinator/educator role is currently vacant.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement	FA	Manor Park Private Hospital has an implemented quality and risk management system. The service quality improvement action plan is discussed at the bi-monthly quality health and safety meeting for progress against identified goals. Caregivers interviewed confirmed that quality data is discussed at monthly staff meetings. There are combined quality 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 on the staffroom noticeboard. There are policies and procedures appropriate for service delivery which are accessible electronically and a hard copy is available for all staff. Policies are reviewed by the facility manager 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. The service completes internal audits as scheduled. Corrective actions identified have been followed up and signed off. This was a finding from the previous audit that has now been addressed. Staff meeting minutes

principles.		include the discussion of all, including incidents/accidents, hazards, infections, concerns/complaints, audit results and corrective actions. This was a finding from the previous audit that has now been addressed. Manor Park Private Hospital completed an annual survey of relatives/friends in August 2020. The facility manager takes the lead and has overall organisational responsibility for health and safety (H&S). Manor Park Private Hospital has a 2020 health and safety plan which includes contractor management, medicine management, infection control, staff wellbeing and hazard management. The health and safety (H&S) committee meets bi-monthly and has representatives across each unit/area and management representatives. 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. The service has a current hazard register, reviewed August 2020. 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. The service has one volunteer who is also the resident advocate, who runs courses for dementia Wellington. He provides support to residents and family/whānau and attends the health and safety quality meeting.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and reported at meetings. Actions are followed up and managed. Ten accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a RN. Neurological observation forms were documented and completed for two unwitnessed falls with a potential head injury. The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 notification made since the last audit for a coroner’s referral.
Standard 1.2.5: Consumer Participation	FA	Manor Park Private Hospital completed an annual survey of relatives/friends in August 2020. This was a finding from the previous audit that has now been addressed. The hospital advocate represents and provides input on behalf of residents and family/whānau at the quality improvement meetings and other, when requested, regular

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.		meetings with management.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	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 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. The manager 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 from 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. 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. 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.
Standard 1.2.8: Service Provider	FA	Staffing rosters were sighted and there is adequate staff on duty in each area to match the needs of the residents. The facility manager, and operations manager work full-time from Monday to Friday. The clinical coordinator works

Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		Saturday to Wednesday with Thursday and Friday off. There are at least two RNs on duty morning and afternoon shifts and one RN on night shift. Endeavour wing is 14 beds with four mental health clients and 10 psychogeriatric residents: Morning shift - two caregivers and afternoon shift - two caregivers. Heritage wing is 14 beds with 14 psychogeriatric residents: Morning shift - two caregivers and afternoon shift – two caregivers. Harris wing is 26 beds with three mental health clients and 23 psychogeriatric residents: Morning shift - four caregivers and afternoon shift - four caregivers (three full shift and one finishing at 9 pm with this shift extending depending on resident acuity). One registered nurse is stationed in Harris for all shifts and supports all areas on night shift. There are three caregivers and one RN on night shift or two caregivers, one enrolled nurse and an RN. The caregivers and registered nurses interviewed stated that there is adequate staffing to manage their workload on any shift. Internal staff cover any leave. Bureau staff may be used for one-on-one with residents as required.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	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. 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. 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.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative	PA Moderate	There are policies and procedures in place for safe medicine management that meet legislative requirements and guidelines. The facility has one medication room that stores the three medication trolleys. 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 and room are maintained within the

requirements and safe practice guidelines.		acceptable temperature range. Not all eye drops, and ointments were dated on opening, and the controlled drug register had not been checked weekly. Ten electronic 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 medication charts included three monthly GP reviews as appropriate. Appropriate practice was demonstrated on the witnessed medication round. 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.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a well-equipped kitchen lead by qualified chefs. 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 expires 2 May 2022. 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 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. 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. 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. Family members interviewed commented positively about the food services.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The mental health files contained the long-term care plans created 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, cigarettes, pain, nutrition and hydration, communication, vision, memory, behaviour and medical needs. One service delivery plan identified early warning signs (link 1.3.6.1). Relapse prevention plans were in place for resident 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.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	All five files including the mental health files contained the long-term care plans created 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, cigarettes, pain, nutrition and hydration, communication, vision, memory, behaviour and medical needs. When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Not all resident care plans sampled included all interventions documented to meet the needs of the resident. Relapse prevention plans were in place for resident whose files were sighted that had been admitted under the Mental Health Act. In the five files sampled there was evidence that the plan had been developed in partnership with the consumer, service provider and family/whānau as appropriate. The family/whānau members interviewed described that they were kept informed of the changes in their family member's condition. Files evidenced input from the community mental health teams. Care staff interviewed stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies. Wound assessment and wound management forms are in place for all wounds. Wound monitoring was not all documented as planned. Photos of wound progress are taken. There were six wounds in all and no pressure injuries. Monitoring forms are in use as applicable, such as: weight; vital signs; food and fluid intake; restraint checks; half-hourly checks; and wounds, however weight management is not consistently documented. Behaviour charts are available for any residents that exhibit challenging behaviours. There is liaison with the mental health for older person's team.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low	The service continues to employ two qualified diversional therapists (DTs) to provide the activities programme seven days a week, with assistance from care staff and additional activity staff as needed. The programme is flexible to meet the resident's needs; it includes individual and group activities. The DTs 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. 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. There are daily happy hours with special snacks and drinks. The service has a hydrotherapy pool that is well utilised for one-to-one and relaxation therapy. Pet therapy is provided by the homes cats and visiting dogs. There is evidence of individual activities occurring that are meaningful to the resident. A music therapist visits weekly, there are beauty days and gym visits.

		Individual activities for the younger residents are identified through the assessment process, but activity plans were not individualised. A resident activity assessment and social profile is carried out as soon as possible after admission, however the individual activity plans did not all match the assessment. Family interviewed stated they felt the activities programme was extensive and individual resident needs and abilities were catered for. Mental health residents have the opportunity to attend the community programme. Both resident files reviewed evidenced that the residents had one-to-one input from the diversional therapy team. There are separate activities for residents with mental illness, which includes access to the community in activities appropriate to their needs.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long-term care plans were in place for two of the three PG resident files reviewed. One resident had not been at the service long enough to have a long-term care plan evaluation. 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. The mental health files reviewed had current long-term care plans based on interRAI six monthly assessments. Both files contained three monthly GP reviews, six monthly Manor Park MDT reviews and monthly reviews by the mental health teams. The family member interviewed said they were invited to reviews and sent copies when they could not attend.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness which expires in February 2021. 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. Building upkeep including a skirting board missing in one of the resident's toilets has been addressed. 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, shade, seating and outdoor tables.

Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	There is a policy describing surveillance methodology for monitoring of infections. 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. There have been no outbreaks. The service allowed no visitors during the Covid-19 lockdown. The residents were confined to their respective units (residents could not be confined to rooms due to the nature of the service). The police visited as did the local council to check Manor Park Hospital were following correct infection control processes during lockdown. This audit confirms that, due to the nature of the service, all possible infection control processes were implemented. Zoom meetings with the DHB and the Ministry of Health were also documented. Families were sent emails and photos and participated in Zoom calls as well.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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 were no restraints or enablers being used at the time of audit.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	There are policies and procedures in place for safe medicine management that meet legislative requirements and guidelines. Not all medication practices such as dating eye drops and checking controlled drug medication were implemented.	(i). Two eye drops had not been dated on opening. (ii). The controlled drug register had not been checked weekly.	(i). Ensure that eye drops are dated on opening. (ii). Ensure that the controlled drug register is checked weekly. 60 days

Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	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.	Two new resident long term care plans from the PG unit were not within set time frames.	Ensure that new residents have care plans documented within time frames 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	All five resident files reviewed had a documented care plan in place. Care plans documented a multidisciplinary approach. Staff described a comprehensive handover and felt that they were well informed regarding resident care needs. There were wound care plans documented for all wounds. Care plan interventions did not address all assessed needs and not all interventions were documented as occurring.	(i). One mental health resident did not have early warning signs documented. (ii). Weights were not recorded for two residents (one mental health, one PG). (iii). One PG resident did not have individualised interventions for behaviours that challenge. (iv). One PG resident did not have nutritional needs included in the care plan or nutrition plan. (v.) Recognition and care of a resident with seizures was not documented for one PG resident file. (vi). One PG resident	(i). Ensure all mental health residents have documented early warning signs. (ii). Ensure weights are recorded as per plan. (iii) – (v) Ensure that care plan interventions address all assessed needs (vi). Ensure that care plan interventions are implemented,

			care plan documented the need for analgesia prior to dressings, this was not documented as implemented. The resident stated that dressings were very painful on interview.	such as analgesia prior to dressings. 30 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	A resident activity assessment and social profile is carried out as soon as possible after admission and evaluated six-monthly as part of the care plan evaluation process, however; the individual activity plans did not all match the assessment.	Activity plans for two PG residents were not individualised to reflect the activity assessment.	Ensure that each resident has an individualised activity plan. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.