# South Canterbury District Health Board - Talbot Park

## Current Status: 14 April 2014

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

**General overview**

An unannounced surveillance audit was undertaken at Talbot Park, an aged care facility that is owned by the South Canterbury District Health Board. Talbot Park is a 76 bed facility in suburban Timaru, South Canterbury, which has two wings with a total of 47 hospital beds and a wing with 29 beds for residents requiring psychogeriatric services.

A three month period of Temporary management has been in place. On the day of audit a new interim manager who had been at the facility for one week was providing oversight while a permanent appointment is being processed.

Service delivery systems that have recently been reviewed are ensuring residents are safe and well cared for.

Areas requiring improvement relate to the management of complaints; documentation about the purpose, values and strategic goals of the service; multiple aspects of the quality management system; records for the appointment of service providers; implementation of the staff training plan and ensuring the general state and cleanliness of the environment meet the standard. Nursing assessments need to be signed, dated and used for care planning in an overt manner; care plan goals need to be individualised; there is a need for a policy for checking hot food temperatures; and the new infection control officer has yet to undertake education for the role. An inconsistency in the completion of medication records, and the need for a co-ordinated approach with the involvement of multidisciplinary professionals, were areas raised for improvement at the previous audit that require further attention to meet requirements.

**Audit Summary as at** **14 April 2014**

Standards have been assessed and summarised below:

### Key

| **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 |
|  | 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 |

### Consumer Rights as at 14 April 2014

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Organisational Management as at 14 April 2014

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| 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. |

### Continuum of Service Delivery as at 14 April 2014

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| 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. |

### Safe and Appropriate Environment as at 14 April 2014

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| 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 medium or high risk and/or unattained and of low risk. |

### Restraint Minimisation and Safe Practice as at 14 April 2014

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| 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. |

### Infection Prevention and Control as at 14 April 2014

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| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of low risk |

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | South Canterbury District Health Board |
| **Certificate name:** | South Canterbury District Health Board - Talbot Park |

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| --- | --- |
| **Designated Auditing Agency:** | The DAA Group Limited |

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| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Talbot Park | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric) | | | |
| **Dates of audit:** | **Start date:** | 14 April 2014 | **End date:** | 14 April 2014 |

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| **Proposed changes to current services (if any):** |
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| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 64 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 8 | **Hours off site** | 6 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXXX |  |  | **Hours** | 4 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 14 | Total audit hours | 30 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 2 | Number of staff interviewed | 11 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 11 | Number of staff records reviewed | 2 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 190 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed |  |

## **Declaration**

I, XXXXXXXX, Managing Director of DAA Group, Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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| --- | --- | --- |
| a) | I am a delegated authority of The DAA Group Limited | Yes |
| b) | The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Not Applicable |
| g) | The DAA Group Limited has provided all the information that is relevant to the audit | Yes |
| h) | The DAA Group Limited has finished editing the document. | Yes |

Dated Friday, 30 May 2014

## **Executive Summary of Audit**

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| **General Overview** |
| An unannounced surveillance audit was undertaken at Talbot Park, an aged care facility that is owned by the South Canterbury District Health Board (SCDHB). Talbot Park is a 76 bed facility in suburban Timaru, South Canterbury, which has two wings with a total of 47 hospital beds and a wing with 29 dementia care service beds. The dementia service beds are currently being held at 25 beds to ensure there is adequate staff coverage.   A three month period of Temporary Management has been in place. On the day of audit a new interim manager who had been at the facility for one week was providing oversight while a permanent appointment is being processed.   Service delivery systems that have recently been reviewed are ensuring residents are safe and well cared for.   Areas requiring improvement relate to the management of complaints; documentation about the purpose, values and strategic goals of the service; multiple aspects of the quality management system; records for the appointment of service providers; implementation of the staff training plan and ensuring the general state and cleanliness of the environment meet the standard. Nursing assessments need to be signed, dated and used for care planning in an overt manner; care plan goals need to be individualised; there is a need for a policy for checking hot food temperatures; and the new infection control officer has yet to undertake education for the role. An inconsistency in the completion of medication records, and the need for a co-ordinated approach with the involvement of multidisciplinary professionals, were areas raised for improvement at the previous audit that require further attention to meet requirements. |

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| **Outcome 1.1: Consumer Rights** |
| The service has policy documents about communication and open disclosure. Open disclosure is occurring following incidents and staff are aware of its importance. The manager has an open door policy.  A documented complaints policy and process is in place, as is a complaints register. Information in the register about one complaint does not accurately reflect information in the complaint itself and a second complaint has not yet been addressed. Ensuring complaints management is consistent with Right 10 of the Code of Health and Disability Services Consumers' Rights is an area requiring improvement. |

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| **Outcome 1.2: Organisational Management** |
| A quality plan 2013 – 2014 is available. This includes a set of quality goals and describes planned quality initiatives. Current documents pertaining to the purpose, values, scope and strategic goals of the service are not available on the day of audit and this is identified as an area requiring improvement. The current temporary manager is suitably qualified and experienced.  Policies and procedures from the local district health board are in use, however not all documents show evidence of having been reviewed and not all apply to Talbot Park. The confusion, about which aspects are specific to the service, as was identified at the previous audit, remains. There are documents being used in service delivery that have not yet been reviewed for document control purposes.   Some monitoring systems have been developed, and are in place, such as an internal audit schedule, a resident satisfaction survey and incident reporting systems. There is a lack of analysis of information obtained from most of these systems, except for incident reporting and restraint use, and there is a general lack of evidence of the review or evaluation of quality data. There is no corrective action plan process and risk management is not specifically addressed in the wider quality plan, or in a separate risk management plan. With partial attainments in all criteria of the standard on quality management systems, the overall rating is high risk.   Staff files are not available at audit. As it is not possible to see how the recruitment or appraisal systems are operating, the appointment of suitable employees is therefore identified as an area requiring improvement. An orientation and induction system is in place. Some gaps in staff training and training records are evident and there has not yet been time to fully implement the staff education plan. These are also areas requiring improvement.  The rosters for each wing indicate sufficient numbers of suitably experienced staff are being allocated and feedback about improved staffing levels was forthcoming. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Service delivery is based on appropriate assessments on admission and on an ongoing basis as required. A previous area regarding all files having appropriately signed admission agreements has been addressed, with files viewed demonstrating compliance. Medical care is provided by a nominated general practitioner, with support from secondary care services if necessary. When assessed as appropriate, patients are reviewed by their GP every three months, and more frequently in response to clinical concerns. Two residents are reviewed using tracer methodology.  Care plans are developed following the completion of discipline specific assessments, which identify appropriate interventions to meet the assessed needs. Residents have access to a range of health professionals when a need is identified. These include specialist nursing services, such as district nursing, wound care, palliative care, community mental health, community elder health, as well as allied health services, such as podiatry, physiotherapy, and dieticians. Services are also provided by a qualified diversional therapist with access to a comprehensive activity/recreational plan as well as individual activities. Whilst there is evidence of multidisciplinary involvement in care provision, there is no evidence of a multidisciplinary approach to the overall plan of care and is an area requiring improvement.  A suite of new nursing documentation has been developed and is going through a transitional phase of introduction. A variety of nursing assessments are available and in use to assess for areas such as risk of falls, pressure areas, nutritional needs, and mobility requirements. An area requiring improvement is the appropriate signing and dating of assessments when completed. Diversional therapists, dieticians and physiotherapists complete assessments as required. Improvements since the previous audit have been made to the documentation and delivery of services specific to challenging behaviour and pain. A new long term care plan has been introduced for all new admissions and is currently being introduced for those residents when their six monthly review of care is required. An area requiring improvement has been identified around the development of individual patient’s goals.  Nutritional assessments are completed for all residents on admission to identify food preferences and their needs. Food is delivered from Timaru Hospital kitchen on individual patient trays, following self-selection from the menu. Residents have access to special menus and a dietitian if required. Improvement has been made to the resident’s access to additional snacks at morning and afternoon tea, as well as at other times, particularly for those patients who have additional food requirements. An area requiring improvement has been identified for the monitoring of food temperatures on delivery from the kitchen.  Medication management is guided by appropriate policies and procedures. Pharmacy services are provided by the pharmacy at Timaru Hospital with all medication delivered in a resident specific pre-packaged system. Nursing and care staff complete medication competencies to ensure they are competent to administer medications. Improvement has been made with regard to the process for faxing medication charts to the pharmacy and the recording of ambient medication room temperatures. New areas requiring improvement include ensuring medication rounds are completed in a timely manner, that the documentation of any delayed medications is accurate, and that the level of detail in all medication charts meets the required standards. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility has a current building warrant of fitness.   An area requiring improvement relates to the environment, which is currently presenting potential health and safety and infection prevention and control risks. There is a need for de-cluttering of the facility; renovation of scraped paintwork, deteriorating shower walls and rusty appearing radiators; the repair of broken equipment and chattels, such as an internal drain cover; and overall cleaning of service areas. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| A restraint coordinator is ensuring restraint minimisation and safe practice policies and procedures are being upheld. Residents who use enablers do so voluntarily and each has comprehensive documentation about this. The use of enablers is included in a register.  Restraint use is minimised with staff attending topical training and restraint use documented. Full assessment, monitoring, review and evaluation processes are in place, a restraint register is being updated and relatives/enduring power of attorneys are being consulted. The areas for improvement raised at the previous certification audit have been addressed. |

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| **Outcome 3: Infection Prevention and Control** |
| Infection prevention and control practices are guided by policies and procedures. Recent changes in the staffing have seen the clinical nurse manager (CNM) appointed to the portfolio for infection control within the previous month, without any formalised orientation or position description for the role. A previous area requiring improvement was identified regarding the professional development for the members of the infection control committee. In light of the recent changes in staffing, this has yet to be addressed; however the CNM is booked to attend an infection control education programme later this year. Whilst there is evidence that infection control specific auditing and infection surveillance activity has been occurring, the CNM confirms that the infection control committee has not met since August 2012, nor has the programme been updated. These are areas requiring improvement. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 13 | 0 | 5 | 4 | 1 | 0 |
| **Criteria** | 0 | 25 | 0 | 13 | 8 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 27 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 55 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.13.1 | The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | The complaints process is not complying with Right 10 of the Code as a significant complaint has not been acknowledged and plans for follow-up have not been activated. | The complaints process is responsive and complies with Right 10 of the Code. | 180 |
| HDS(C)S.2008 | Criterion 1.1.13.3 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | Records in the complaints register are inaccurate, documentation in the file is not secure and the register does not include a record of the planned actions. | The complaints register is accurate and up to date. | 180 |
| HDS(C)S.2008 | Standard 1.2.1: Governance | The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.1.1 | The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Moderate | There is no documentation available on the day of audit that specifically identifies the purpose, values or direction of the organisation. The goals available are not of a strategic nature and there is no indication when the document about the scope and commitment of the service was last reviewed. | The purpose, values, scope, direction and goals of the organisation are clearly identified and regularly reviewed. | 90 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA High |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.1 | The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Moderate | Limited elements only of a quality and risk management system are being implemented; however these do not address quality improvement or risk management. The quality plan available does not address risk management and there is not currently a specific person, or committee, responsible for its implementation. Overall, quality and risk is not being addressed in a systematic way. | A quality and risk management system that is understood by service providers, and is led in an accountable manner, is required. | 90 |
| HDS(C)S.2008 | Criterion 1.2.3.3 | The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | The policies and procedures available have not all been reviewed according to the requirements in the indices and do not all necessarily align with practices and processes at Talbot Park. | Policies and procedures are reviewed within the timeframes indicated and they align with the practices and processes that are applicable to Talbot Park. | 180 |
| HDS(C)S.2008 | Criterion 1.2.3.4 | There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents. | PA Low | Not all documents in use at Talbot Park, in particular documents in client files for service delivery, are controlled documents. | All documents assigned for official use within the service are approved and included in the document control system. | 180 |
| HDS(C)S.2008 | Criterion 1.2.3.5 | Key components of service delivery shall be explicitly linked to the quality management system. | PA Moderate | Efforts are being made to monitor and measure some aspects of service delivery for quality improvement purposes; however except for restraint use these are not currently contributing to quality improvement. Key components of service delivery are not being explicitly linked to quality management/quality improvement as there is no formalised quality system. | Key components of service delivery, that include event reporting, complaints management, infection control, health and safety and restraint minimisation are explicitly linked to a quality management system, which includes the identification of issues, implementation of corrective actions and evaluation and review of these. | 90 |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | The collection and analysis of quality improvement data is minimal, with no evaluation of it occurring, except for restraint use. There is a lack of evidence to demonstrate that any data collected is being used for quality improvement purposes. | Quality improvement data that relates to the goals and objectives of the quality plan is collected, analysed and evaluated for quality improvement purposes and communicated to service providers in a consistent manner. | 180 |
| HDS(C)S.2008 | Criterion 1.2.3.7 | A process to measure achievement against the quality and risk management plan is implemented. | PA Moderate | There are examples of processes to measure achievement against the quality plan being implemented for some aspects of quality management. These are not consistent, do not include risk management and do not measure overall achievement against the quality plan. The internal audit schedule is not occurring as documented. | A process is implemented by which achievements against a risk quality and risk management plan are consistently measured. | 90 |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | Evidence of corrective action plans to address areas requiring improvement in order to meet standards or requirements are not available at audit. | A corrective action planning process to address areas requiring improvement is implemented. | 90 |
| HDS(C)S.2008 | Criterion 1.2.3.9 | Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Moderate | A risk management plan that identifies actual or potential organisational risks and the level of associated risk is not available and there is no evidence of the monitoring, analysis or evaluation of risks. | Actual and potential organisational risks that are associated with providing services at Talbot Park are identified and documented and they are monitored, analysed, evaluated and reviewed at a frequency determined by the severity of risk and the probability of change in the status of that risk. | 90 |
| HDS(C)S.2008 | 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. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.3 | The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Because staff appointment and performance appraisal information is held on file in the SCDB human resources department, it is not possible on the day of audit to confirm that recruitment and performance appraisal processes in place are ensuring the appointment of appropriate service providers that will safely meet the needs of the residents, . | That evidence is provided to confirm the appointment of appropriate service providers to safely meet the needs of consumers. | 180 |
| HDS(C)S.2008 | Criterion 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | A system to identify, facilitate and record ongoing education for service providers has been developed, however there is not yet evidence available to show this is embedded into the management systems at Talbot Park | The staff education plan is instituted, staff training records are updated and staff education that will ensure safe and effective services to residents is maintained. | 180 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Low |  |  |  |
| HDS(C)S.2008 | 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 Low | Resident file reviews demonstrate that there are instances where it is difficult to determine if assessments are occurring within expected timeframes as they are not always dated and signed by the nurse completing the assessment. Examples include falls action plans, sensor mat assessments, pressure area assessments, and continence assessments, without a completion date. | Ensure all nursing assessments and documentation used to record service delivery are appropriately dated and signed at the time of completing the assessments. | 180 |
| HDS(C)S.2008 | Criterion 1.3.3.4 | The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | The previous audit in 2012 identified a requirement for a multidisciplinary approach to ensure the continuity of services; however nine clinical files reviewed, and the CNM, diversional therapist and two HCAs confirm that there has been no formalised multidisciplinary team planning implemented. | The service ensures continuity of services through a multidisciplinary approach to care planning and service delivery | 180 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.4.2 | The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | The new care plan utilises pre-formatted patient goals that are not individualised to the resident.   Four of the eight clinical files reviewed demonstrate that the pressure area assessment and falls risk assessment are completed as required; however, overall scores are not provided which identify the level of risk to the resident. The observed interventions that have been implemented to mitigate risk are not always documented in the care plan | Ensure nursing assessments document goals that are individualised to the resident. Ensure assessment tools are completed, totalled, and appropriate interventions to mitigate the risk are clearly documented in the care plan and evaluated as required. | 180 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | 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 | An 8 am medication round is observed to be still underway at 9.40 am. A review of two resident's medication charts for which medications are dispensed for at 9.40 am documents that these medications have been signed as being given at 8 am. | Adequate staffing is available and processes in place to ensure medication rounds are completed within the expected timeframes. Ensure that the correct time of medication administration is documented in the medication chart. | 90 |
| HDS(C)S.2008 | Criterion 1.3.12.6 | Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | Four medication charts do not have indications for PRN medications documented; four charts have bracketing of dates for medications; two charts do not have the allergy status documented; and one of three charts where a drug allergy is identified has used the additional drug allergy alert sticker.  The controlled drug register demonstrates that ‘end of the page stock counts’ are occurring, however there is no evidence that 6 monthly quantity stock checks are occurring as required. | Ensure the medication charts are completed and quantity stock checks are undertaken as per the legislated requirements | 180 |
| HDS(C)S.2008 | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | The temperature of food on delivery from the central kitchen at the nearby DHB hospital is not routinely monitored or recorded. | Develop a policy and process to ensure that the temperature of food is monitored and recorded. | 180 |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.4 | The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Moderate | There is potential health and safety risks associated with equipment being stored inappropriately, equipment being in a state of disrepair, deteriorating wall linings and paintwork, an open drain and a general state of unclean service areas and equipment. The dementia wing is a clinical environment for such a facility in 2014. | The state of the physical environment and equipment is reviewed and actions taken to ensure all areas minimise risk of harm to residents and to staff and to ensure it is appropriate to meet the needs of the residents. | 90 |
| HDS(IPC)S.2008 | Standard 3.2: Implementing the infection control programme | There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | PA Low |  |  |  |
| HDS(IPC)S.2008 | Criterion 3.2.1 | The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard. | PA Low | Meeting minutes indicate that the infection control committee has not been active since August 2012. The Infection Control Programme/Plan has not been updated since July 2102. The CNM confirms that she has not received any formal orientation to the infection control role, nor holds a position description that clearly outlines the roles and responsibilities of this position. | Ensure the Infection Control Committee is re-established, the CNM is formally orientated to the infection control role, and processes are put in place to update the infection control programme and action plan for ongoing infection control activities including clinical and environmental audits | 180 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

#### Standard 1.1.9: Communication **(**HDS(C)S.2008:1.1.9)

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

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policy documents on communication and open disclosure and these are sighted. According to the staff interviewed, each manager has had an open door policy. Four hospital aides relates stories that demonstrate their awareness of the need for open communication, including for people with dementia, and of their responsibility to talk to more senior staff if they believe this is warranted. Although not ticked in older incident forms, there is evidence on all incident forms on file from the past two months that relatives/next of kin have been contacted. The temporary manager and the clinical nurse manager inform they are developing a form for relatives to sign about the level of contact they want to receive.   The temporary manager informs they have access to the SCDHB interpreter services, as per the SCDHB policy and procedure if required. The clinical nurse manager informs that one current resident from another culture has dementia and has reverted back to her native tongue. Staff who speak this language communicate with her accordingly; however they also report that there are no indications that this assists her. There are not currently any other residents who require interpreter services. |

##### **Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)**

Wherever necessary and reasonably practicable, interpreter services are provided.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.1.13: Complaints Management **(**HDS(C)S.2008:1.1.13)

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

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| A complaints process is documented in a SCDHB policy and procedure, although senior staff are not aware of the requirements of this complaints process. Four of four hospital aides inform they would report any complaint to a registered nurse and know there is a form they can refer any person to. Two complaints are noted in a complaints register. Details in the register for the first complaint are incorrect as it notes the complaint was filed in late January 2014, when the accompanying notes about the complaint are initially dated December 2013. An update is recorded late February 2014 and the date of resolution was late March 2014. The second complaint was filed late March 2014 and although noted in the register there is no details of the nature of the issue and no evidence of follow-up having occurred yet. The complainant has not had the complaint acknowledged within the five days as required by the Right 10 of the Code and the plan proposed by the manager has not yet been activated. Ensuring the complaints process is followed and maintaining accurate records in the complaints register are areas for improvement. |

##### **Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)**

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The SCDHB policy and procedure for managing complaints is used by this facility and a copy is inside a folder for complaints and compliments. Records of a complaint filed in March 2014 show that the complaint has not been acknowledged, despite and the planned actions for addressing the complaint are not yet underway. Ensuring the complaints process meets requirements is an area for improvement. |
| **Finding:** |
| The complaints process is not complying with Right 10 of the Code as a significant complaint has not been acknowledged and plans for follow-up have not been activated. |
| **Corrective Action:** |
| The complaints process is responsive and complies with Right 10 of the Code. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A complaints register has been implemented within the past three months. This holds two records, one of which notes the complaint was filed in January 2014, when the initial correspondence about the complaint is dated December 2013. The second complaint about staff conduct is of significance and is noted on the register, however details about it are on loose papers tucked inside and falling out of the folder. Although filed late March 2014 the complainant has not yet received acknowledgement of the complaint and the plans to address it have not yet been activated. |
| **Finding:** |
| Records in the complaints register are inaccurate, documentation in the file is not secure and the register does not include a record of the planned actions. |
| **Corrective Action:** |
| The complaints register is accurate and up to date. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **Outcome 1.2: Organisational Management**

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

#### Standard 1.2.1: Governance **(**HDS(C)S.2008:1.2.1)

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

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a quote “A genuine approach to care” on a number of documents. Its source, or its relevance, for Talbot Park is not able to be found. A set of quality goals sits within a quality plan dated 2013 – 2014 (sighted). Although some of these are of an organisational nature, there is no evidence of strategic goals for the service available on the day of audit. Similarly, although the scope and commitment of the service are available on a promotional brochure there is no evidence of when these were last reviewed and there is no other evidence of official or controlled documentation about the purpose, values, scope, direction and goals of the organisation available. This is an area requiring improvement.  The position of facility manager is currently being advertised. On the day of audit a suitably qualified and experienced Interim manager who has worked six days, only four of which have been on site, is in place. The Interim manager replaces a three month placement of a previous Temporary manager. A curriculum vitae of the Interim manager is sighted and shows she has a background in working in aged care and other ‘change-focused’ management and coordination roles. She is a registered nurse with a current practising certificate, has a Bachelor of Nursing degree and is maintaining her professional development with further post-graduate courses. Her usual role is as a family violence coordinator with the SCDHB. |

##### **Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)**

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| A promotional brochure about Talbot Park is available and describes the scope of services provided and the commitment of the service. There is no indication of when these were last reviewed, or when the document was last published. A set of goals is sighted in the 2013- 2014 quality plan; however these are orientated towards quality management, rather than being of a strategic nature. No other documentation is able to be provided on the day of audit that specifically describes the purpose, values, direction and goals of the organisation. |
| **Finding:** |
| There is no documentation available on the day of audit that specifically identifies the purpose, values or direction of the organisation. The goals available are not of a strategic nature and there is no indication when the document about the scope and commitment of the service was last reviewed. |
| **Corrective Action:** |
| The purpose, values, scope, direction and goals of the organisation are clearly identified and regularly reviewed. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.3: Quality And Risk Management Systems **(**HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

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| **Attainment and Risk:** PA High |
| **Evidence:** |
| A quality plan dated July 2013 and titled ‘A genuine approach to care’ is sighted. This is comprehensive for quality management purposes, but does not specifically include risk management. Managers spoken with inform that quality management was previously overseen by a quality manager from the SCDHB; however this is not currently occurring. There is no evidence of a quality management structure, committee or forum to oversee quality management/quality improvement or to implement the quality plan, and this is an area for improvement. The quality plan mentions quality improvement initiatives, such as the use of interRAI, however their implementation is not yet evident.  A folder containing minutes of meetings for health and safety; diversional therapy; operational and hospital aides; includes terms of reference for each. Other than weekly staff meetings that were reported by the clinical nurse manager as being instituted to keep staff up to date with all the changes that were occurring, there is limited evidence that the other meetings have been occurring since mid-2013. Agenda items that relate to quality management are included in weekly staff meeting minutes, however these are dealt with at a reporting level, rather than addressing them for quality improvement purposes.   Policy and procedure manuals owned by the SCDHB are sighted and include protocols and procedures practice manual, a clinical service practice manual with a separate one for medication, human resources and a health and safety folder. There are documents in the policy and procedure manuals that are overdue for review and there is confusion as to which documents relate to Talbot Park. Addressing these issues continues to be an area for improvement, as raised at the previous audit. A controlled documents policy and procedure notes that all documents used by the service, including forms, are to be controlled, however since a recent review of service delivery a number of forms and templates now being used in service delivery files are not controlled and this is an area requiring improvement.   The main sources of quality improvement data are for restraint use, infection surveillance and incident/event reporting and this data is being monitored, measured and analysed, although not reviewed or evaluated. Similarly a 2013 residents’ survey was undertaken but no analysis has occurred. Shortcomings are being identified but are not being followed up with corrective actions. There is a need to broaden the range of data collected, including for health and safety, as per the quality plan and to ensure any shortcomings are identified. Corrective actions need to be developed for quality improvement purposes for all components and processes and actions/results need to be evaluated and reviewed. Given there is no formal quality management system in place, this is currently difficult to achieve.   As noted above, the quality plan does not include risk management. There is also no separate risk management plan that identifies actual and potential organisational risks and therefore there is no evidence of the monitoring, analysis or evaluation of risks. These are also area requiring improvement. Risks are being identified for individual residents and ways of mitigating these are being implemented in some cases; however this is inconsistent and is identified as an area requiring improvement in 1.3.4.2.  Overall the requirements for this standard are partially attained as every criterion identifies varying levels of risk. |

##### **Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)**

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| A quality plan for 2013 – 2014 is available and is sighted. This does not include risk management. The clinical nurse manager informs that a quality manager from the SCDHB was coming across on a weekly basis but this is no longer occurring. There is not currently a quality and risk management committee or structure that supports quality and risk management at Talbot Park. To ensure staff are kept informed of changes at Talbot Park, staff meetings are currently being held weekly, although the temporary manager informs that due to decreasing attendance these will be moved to fortnightly. The minutes of these include elements of quality and risk issues but do not include evidence of quality improvement or quality assurance activities that will ensure the safety of residents, of staff, or of Talbot Park as an aged care facility. |
| **Finding:** |
| Limited elements only of a quality and risk management system are being implemented; however these do not address quality improvement or risk management. The quality plan available does not address risk management and there is not currently a specific person, or committee, responsible for its implementation. Overall, quality and risk is not being addressed in a systematic way. |
| **Corrective Action:** |
| A quality and risk management system that is understood by service providers, and is led in an accountable manner, is required. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Policy and procedure manuals are held in the manager’s office. These are the official manuals of the SCDHB. In addition to the fact that not all policies and procedures have been updated according to the indices, there is a lack of clarity about those that relate to Talbot Park and those that are not applicable. Some medicine management policies and procedures are duplicated with versions in one manual and versions in another. The area for improvement raised at the previous audit has yet to be addressed. |
| **Finding:** |
| The policies and procedures available have not all been reviewed according to the requirements in the indices and do not all necessarily align with practices and processes at Talbot Park. |
| **Corrective Action:** |
| Policies and procedures are reviewed within the timeframes indicated and they align with the practices and processes that are applicable to Talbot Park. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The document control system is implemented and overseen by the SCDHB. There are documents that have been implemented following a review of service delivery that have not yet been considered by document reviewers and are not yet controlled documents. |
| **Finding:** |
| Not all documents in use at Talbot Park, in particular documents in client files for service delivery, are controlled documents. |
| **Corrective Action:** |
| All documents assigned for official use within the service are approved and included in the document control system. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)**

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The quality plan is sighted and explicitly includes key components of service delivery. Some aspects of quality management, such as restraint use, incidence of infections and incident reporting are being addressed by different staff and managers and are discussed at the weekly staff meetings. Complaints management does not meet requirements as identified in 1.1.13 and there is no evidence of how health and safety is being monitored. The quality cycle of those that are being addressed (except for restraint use) is not being completed through to action, evaluation and review. |
| **Finding:** |
| Efforts are being made to monitor and measure some aspects of service delivery for quality improvement purposes; however except for restraint use these are not currently contributing to quality improvement. Key components of service delivery are not being explicitly linked to quality management/quality improvement as there is no formalised quality system. |
| **Corrective Action:** |
| Key components of service delivery, that include event reporting, complaints management, infection control, health and safety and restraint minimisation are explicitly linked to a quality management system, which includes the identification of issues, implementation of corrective actions and evaluation and review of these. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)**

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Information in relation to restraint use is being analysed, evaluated and reviewed, with the inclusion of family members for individual restraint use.   Data related to incident reports is being graphed and analysed. The form in use for the analysis of incident reporting has a section for issues identified and corrective action; however these are not being consistently completed. The results of three internal audits undertaken are on file; however there is no evidence of the information obtained being used for quality improvement purposes. There is also no evidence of evaluation or review of the minimal data available. Incident reporting data and graphs are made available to staff with copies on the staff room noticeboard. The incidence of infections are being reported at staff meetings, however there is no evaluation or review of them evident.   Other quality improvement data in relation to issues, such as risk management, health and safety or staff training, for example, is not available. |
| **Finding:** |
| The collection and analysis of quality improvement data is minimal, with no evaluation of it occurring, except for restraint use. There is a lack of evidence to demonstrate that any data collected is being used for quality improvement purposes. |
| **Corrective Action:** |
| Quality improvement data that relates to the goals and objectives of the quality plan is collected, analysed and evaluated for quality improvement purposes and communicated to service providers in a consistent manner. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Examples of processes in place that measure achievement against the quality and risk management plan include a resident satisfaction survey, an internal audit schedule, incident reporting and weekly staff meetings. There is no evidence of actions or reviews associated with the information from the 2013 satisfaction survey, which has not been analysed, nor for the few internal audits that have occurred.   A process by which to monitor and measure the goals and objectives of the quality plan as an entity is not evident. As there is no overarching quality structure within the service, the objectives in the plan are not all being reviewed or evaluated. |
| **Finding:** |
| There are examples of processes to measure achievement against the quality plan being implemented for some aspects of quality management. These are not consistent, do not include risk management and do not measure overall achievement against the quality plan. The internal audit schedule is not occurring as documented. |
| **Corrective Action:** |
| A process is implemented by which achievements against a risk quality and risk management plan are consistently measured. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)**

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There are reports from the clinical nurse manager about issues of concern being followed through and resolved. Examples of issues that demonstrate that standards, requirements or expectations not being met are evident, however there are no corrective action plans evident to address them. For example, shortcomings are being identified in the few internal audits undertaken but no plans of how these will be addressed are available. Similarly, in the analysis of incidents with examples being the higher number of falls one month, or 10 cases of unexplained bruising, there is no evidence of identifying the underlying cause and/or the development of a corrective action plan to rectify the situation. |
| **Finding:** |
| Evidence of corrective action plans to address areas requiring improvement in order to meet standards or requirements are not available at audit. |
| **Corrective Action:** |
| A corrective action planning process to address areas requiring improvement is implemented. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)**

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:  
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;  
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| A risk management plan for Talbot Park that identifies actual and potential risks is not available on the day of audit. No evidence of the monitoring, analysis or evaluation of risks is sighted.   Risks are being identified for individual residents and ways of mitigating these are reported by the registered nurse; however these are not always being documented. This is raised as an area requiring improvement in 1.3.4.2. |
| **Finding:** |
| A risk management plan that identifies actual or potential organisational risks and the level of associated risk is not available and there is no evidence of the monitoring, analysis or evaluation of risks. |
| **Corrective Action:** |
| Actual and potential organisational risks that are associated with providing services at Talbot Park are identified and documented and they are monitored, analysed, evaluated and reviewed at a frequency determined by the severity of risk and the probability of change in the status of that risk. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.4: Adverse Event Reporting **(**HDS(C)S.2008:1.2.4)

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The temporary manager and the clinical nurse manager are aware of their obligations in relation to essential notification reporting and the temporary manager informs of close links with a SCDHB line manager and with the DHB portfolio manager.  Adverse, unplanned and untoward events are being recorded on incident forms. These are being followed up and the forms include evidence of open disclosure occurring with family/next of kin in those sighted for the past two months. Previous examples sighted do not have evidence of this. Data related to incident reporting is being collated and graphed and a summary of analysis made. Up to date incident graphs are available for each wing and include data by wing and by category of incident. This information is relayed at staff meetings and the graphs are posted on the staff room noticeboard. As noted in 1.2.3, an area for improvement is that issues need to be consistently identified on the relevant section of the form, corrective actions implemented and the actions are to be reviewed and evaluated. |

##### **Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)**

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.7: Human Resource Management **(**HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Records of annual practising certificates for the registered and enrolled nurses were brought over from the SCDHB human resource department, where they have previously been stored, and are sighted.   It is not possible to confirm that appropriate service providers are being appointed as only the partial content of two staff files are available to view. The temporary manager and a staff person from the SCDHB human resources department inform that all Talbot staff records are currently held at the SCDHB human resources department. Hence this has been identified as an area for improvement as it is not able to be validated at audit.   A reviewed orientation and induction programme has been developed and records of two staff who have recently been employed having completed this are sighted. Four hospital aides confirm during interview that new staff receive an orientation and induction and that the ‘buddying’ system works well. The temporary manager states that all of those currently being interviewed for hospital aide positions will undertake the orientation and induction programme, which the clinical nurse manager confirms is usual practise.   A registered nurse is in the role of education coordinator and has been allocated one day a week for this role. A training schedule for 2014 has been developed and processes are in place to enrol ten of the newer hospital aides into the Careerforce national certificate in health, disability and aged support. Signed applications are sighted. Records viewed and a conversation with the education facilitator confirm that only two of five scheduled internal training sessions for 2014 have occurred as planned and to date these have not been rescheduled. Hospital aides note during interview that over the past 12 to 18 months training opportunities have become minimal but that the previous temporary manager had reinstated some staff training sessions. An example is the provision of a session on challenging behaviour in February 2014. Staff training records sighted show that core training of first aid and fire/emergency management are mostly up to date with only 15 overdue from December and two yearly non-violent crisis intervention training is being scheduled and attended. A plan to address gaps in staff training provision and records has been developed, however to date this has not been fully implemented and there are many core training topics overdue for updates for some staff, such as client rights and manual handling, for example. Ensuring the staff education plan is implemented and staff training records are maintained are areas for improvement. |

##### **Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)**

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are substantial recruitment policies and procedures in the SCDHB human resource manual. The partial content of two staff files are available to view on the day of audit. All remaining staff appointment and performance appraisal information is held on file in the SCDB human resources department. As it is not possible to sight this during the audit, confirmation that appropriate service providers are being appointed to safely meet the needs of residents cannot be made. |
| **Finding:** |
| Because staff appointment and performance appraisal information is held on file in the SCDB human resources department, it is not possible on the day of audit to confirm that recruitment and performance appraisal processes in place are ensuring the appointment of appropriate service providers that will safely meet the needs of the residents, . |
| **Corrective Action:** |
| That evidence is provided to confirm the appointment of appropriate service providers to safely meet the needs of consumers. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A registered nurse has been allocated one day a week to spend on developing a system to identify, facilitate and record ongoing education for service providers. With assistance from the previous temporary manager, the system is now in place and includes the development of a training schedule, the development of a spreadsheet that enables the identification of staff training requirements, in particular for fire training and non-violent crisis intervention, and a register of staff training records. Two of the five training sessions scheduled for 2014 have not occurred as planned with no rescheduled date available. There are significant gaps in the staff training records sighted with some not having completed manual handling, or privacy, for example, since 2006 and 2008. Some of the individualised staff training records are blank, or have one entry only on them. |
| **Finding:** |
| A system to identify, facilitate and record ongoing education for service providers has been developed, however there is not yet evidence available to show this is embedded into the management systems at Talbot Park |
| **Corrective Action:** |
| The staff education plan is instituted, staff training records are updated and staff education that will ensure safe and effective services to residents is maintained. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.8: Service Provider Availability **(**HDS(C)S.2008:1.2.8)

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

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A policy on service provider levels and skill mix is not able to be found on the day of audit. However, the temporary manager, a human resources person from the SCDHB and the clinical nurse manager independently inform that they use SCDHB staff allocation guidelines to develop the roster. Examples of parameters used include that only staff trained, or undergoing training in dementia may work in the dementia wing; a mix of more experienced staff are rostered together, rather than all new staff; and there is an awareness of staff training and/or specific skills required, as with medicine competencies and managing challenging behaviours, for example. Records sighted show that all staff have current training in first aid, or are scheduled for the next update in May 2014.   Four hospital aides inform during three separate interviews that since staffing levels were increased while the previous temporary manager was in place, the overall safety for staff and residents has improved. They inform that there are occasions when compromises are not optimum but this is now rare.  At least one registered nurse, one enrolled nurse and three hospital aides are rostered on night duty 10.30 pm to 7 am. The clinical nurse manager informs that two more registered nurses are currently being employed and orientating for the dementia service and this will enable a registered nurse to be available in the dementia service on seven nights of the week.  A copy of the master roster is provided and reviewed with the shifts being covered as follows:  Watlington wing - Dementia service: A registered nurse is on duty 6.45 am to 3.15pm and 2.30pm – 11pm on seven days a week, although the weekend duties are not always able to be covered at this point.  Hospital aide morning shifts vary from 7am to 3.30pm (two staff); 8.30am to 12.30pm (two staff); 7.30am to 12.30pm; 7,30am to 1.30pm; 7am to 2.00pm. Same at weekends.  Hospital aide afternoon shifts vary from 5.30pm – 10.30pm; 3.30pm – 11pm; 2.00pm – 10.30pm (not weekend); 4.30pm – 11.30pm (not weekend); 3.30pm – 10.30pm; 5.00pm – 11.00pm; 4.00pm – 10.00pm. Hunter wing:  An enrolled nurse is on duty 6.45 am to 3.15pm and 3pm to 10.30pm.  Hospital aide shifts are 6.45am-3.15pm and 7.30am-1.30pm including weekends and afternoon duties are 4pm-9pm; 4.30pm-9.30pm including weekends. Otipua wing:  A registered nurse is on duty 6.45 am to 3.15pm and 2.30pm – 11pm on seven days a week. Hospital aide morning shifts vary from 7am to 3.30pm (three staff); 8.30am to 12.30pm (two staff); 7,30am to 1.30pm; 7am to 1.30pm. Weekends have 7am to 3.30pm (four staff); a 7.30am to 1.30pm person and one on 8.30 am to 12.30pm. Hospital aide afternoon shifts vary from 3.30pm – 10 or 11pm; 3.30pm – 10.30pm; 5.00pm – 11.30pm (two staff); 5.00pm – 9.00pm. There are some variations of times at weekends with five staff covering these timeframes.  A diversional therapist works 8.30 am – 5pm Monday to Wednesday. Two diversional therapist assistants are rostered on duty over seven days 9.30 or 10.00am – 4.30pm and 10.30 am – 7.30pm. Casual staff are listed on the roster for extra shifts as required when acuity of care increases. On the day of audit interviews are underway to increase the number of hospital aides. |

##### **Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **Outcome 1.3: Continuum of Service Delivery**

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

#### Standard 1.3.1: Entry To Services **(**HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Admission agreements are in place with evidence of these agreements within the nine clinical files reviewed. The agreements are appropriately signed by the resident or their nominated representative. Where a nominated representative has signed the agreement there is also evidence of the enduring power of attorney (EPOA) within the file, and that the holder of that EPOA has signed agreement. The previous area for improvement has been addressed. |

##### **Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.3: Service Provision Requirements **(**HDS(C)S.2008:1.3.3)

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

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The provision of services at Talbot Park is provided by a multidisciplinary team (MDT) of health care professionals who hold the appropriate qualifications and practising certificates when required. Staff undergo role specific orientation to the South Canterbury District Health Board and to Talbot Park on employment. When specific competencies are required (e.g., medication administration), staff complete competency packages which include practical assessment. The multidisciplinary team includes general practitioners, registered nurses, enrolled nurses, health care assistants, dietitian, physiotherapist, diversional therapist and assistants, as well as external providers such as specialist medical teams, including mental health, older people, and specialist nurses.  Patients are assessed on admission by their general practitioner and are assessed for appropriateness for three month reviews. Processes are in place to ensure the three monthly reviews occurs as required, which is evidenced in clinical files reviewed. There is also evidence that the patients have access to GPs in response to changes in clinical condition, as well as referral to other providers from the MDT. A range of nursing assessments are undertaken on and throughout admission in response to assessed needs, however, with inconsistency in the dating of these assessments it is unable to be determined that these are occurring in a timely fashion, and this is an area requiring improvement.  Whilst the progress notes reviewed in eight clinical files demonstrate a number of disciplines involved in service delivery, they are recorded independently and there is no evidence that MDT review of the patients is occurring on a regular basis. The CNM confirms that there is no formalised MDT review of the patients. This is an area for improvement that has yet to be addressed from the previous audit. |

##### **Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)**

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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A range of new nursing assessments and documentation to support care planning are in the process of being introduced across the facility, consequently there is still a mix of the old documents with the ‘new’ documents. A review of 9 client files demonstrate that services provided are occurring within expected time frames, in line with the documented policy. There is evidence that a number of assessments are completed to inform the service delivery plan and to meet the patient’s needs, however, there is inconsistencies in the signing and dating of the assessments by the nurse completing the assessments.  General practitioner admission assessments are documented, as are the ongoing three monthly reviews, within the required timeframes. When required to be assessed by other services, such as physiotherapy, dietitian, specialist nursing services, or GPs outside of scheduled visits, there is evidence that these assessments are occurring as required. The CNM confirms good relationships with other services and timely access when required.  Two residents are reviewed using tracer methodology.  Tracer 1 is an inpatient in the dementia unit.  *XXXXXX This information has been deleted as it is specific to the health care of a resident.*  *.* Tracer 2 is a resident in the hospital wing.  *XXXXXX This information has been deleted as it is specific to the health care of a resident.* |
| **Finding:** |
| Resident file reviews demonstrate that there are instances where it is difficult to determine if assessments are occurring within expected timeframes as they are not always dated and signed by the nurse completing the assessment. Examples include falls action plans, sensor mat assessments, pressure area assessments, and continence assessments, without a completion date. |
| **Corrective Action:** |
| Ensure all nursing assessments and documentation used to record service delivery are appropriately dated and signed at the time of completing the assessments. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Patients have access to a number of services that comprise a multidisciplinary team, including diversional therapists/assistants, GPs, Elder Health team including geriatrician, physiotherapists, and dietitians, specialist nursing services such as district nurses, palliative care nurses, continence nurses and wound care nurses. Policies and procedures are in place to guide referral to these services.   The current documentation demonstrates that the individual disciplines are documenting their involvement in service delivery. The CNM confirms that unit meetings are held to discuss the needs of the residents and any specific issues that have been identified, however these meetings are for the registered or enrolled nursing staff only. The diversional therapist confirmed there are communication processes with nursing staff and input into the planning of care, but confirms that this does not occur within a formal process. Two health care assistants (HCAs) confirm that they are not including in these meetings. There is no evidence in the nine clinical files reviewed that there is a formalised multidisciplinary plan of care. |
| **Finding:** |
| The previous audit in 2012 identified a requirement for a multidisciplinary approach to ensure the continuity of services; however nine clinical files reviewed, and the CNM, diversional therapist and two HCAs confirm that there has been no formalised multidisciplinary team planning implemented. |
| **Corrective Action:** |
| The service ensures continuity of services through a multidisciplinary approach to care planning and service delivery |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.4: Assessment **(**HDS(C)S.2008:1.3.4)

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

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A suite of new nursing documentation has been introduced recently and is being used routinely for all new admissions. A process of moving towards the new documentation for existing residents is occurring, but not yet completed. A new Long Term Care Plan is in the process of being introduced for residents at the time of their six month review. The document is comprehensive and forms the basis for service delivery. Each component of the care plan documents the goals for the residents as well as an opportunity to evaluate progress towards the achievement of goals. The goals are pre-formatted and are not individualised to the resident and this requires improvement.  A range of assessments are available. They are discipline specific, appropriate to the facility and are used to assess the needs of the residents. Improvements have been made to the assessment of pain with a new tool and documentation. This includes a tool for those who are unable to verbally communicate pain. The previous corrective action has been addressed.   Tools used to assess risk, such as for falls and pressure areas are utilised, however, are not consistently totalled, and thus are not calculating the level of risk for that resident. It is evident on observation and confirmed by a registered nurse (RN), there are strategies implemented to mitigate risk, however, they are not always documented in the care plan. This is an area requiring improvement. |

##### **Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)**

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A suite of new nursing assessment and care planning documents have been recently introduced, with nurses going through a process of replacing existing long term care plans with the new document as the residents are due for six monthly reviews. The Long Term Care Plan includes an overall risk assessment identification, assessment for mobility, continence/elimination, activities of daily living/hygiene and grooming, dietary needs, medication, pain management, sleep/comfort, intimacy/sexuality, communication/sensory, memory loss/confusion, behaviour management, respiratory function, spiritual/cultural/social, skin/wound care, as well as the opportunity to identify any other needs specific to the resident. Of those files reviewed, two residents have had this new document completed appropriately and this forms the basis for the provision of service delivery. The diversional therapist completes a separate assessment and confirmed that goals are developed that are specific to the residents and support the provision of activities within the recreational/diversional therapy programme.  This new care plan provides opportunity for evaluation of meeting documented goals. There is no evidence that these goals are individualised to the residents with the exception of crossing out one of the goals if they do not apply.   Tools utilised to assess risks, such as falls and pressure areas, are not consistently completed, or totalled to determine the level of risk. The risks are reported in the care plan and it is observed that interventions are in place to mitigate the risk; however these interventions are not always documented in the care plan.  A detailed pain assessment is available with options to use either a numerical scale or the Wong-Baker visual scale. If the resident is unable to verbalise pain, and additional Abbey Pain Scale assessment tool is available. This initial assessment tool is supported by a review of pain assessment document for the ongoing monitoring of pain. There was evidence in clinical files that these documents are used appropriately. This addresses a prior area for improvement. |
| **Finding:** |
| The new care plan utilises pre-formatted patient goals that are not individualised to the resident.   Four of the eight clinical files reviewed demonstrate that the pressure area assessment and falls risk assessment are completed as required; however, overall scores are not provided which identify the level of risk to the resident. The observed interventions that have been implemented to mitigate risk are not always documented in the care plan |
| **Corrective Action:** |
| Ensure nursing assessments document goals that are individualised to the resident. Ensure assessment tools are completed, totalled, and appropriate interventions to mitigate the risk are clearly documented in the care plan and evaluated as required. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.5: Planning **(**HDS(C)S.2008:1.3.5)

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

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Service delivery plans are in place for all residents and clearly describe the interventions required. The new long term care plan ensures that the resident is assessed for their spiritual/cultural or social needs, with appropriate interventions documented which are linked to the information gathered from the assessment. Behaviour management is assessed within the long term care plan. In response to any behaviour that requires management, a separate challenging behaviour assessment document is completed. In one file reviewed, there is evidence of one resident who is described as having challenging behaviours for the staff to manage. The RN confirmed the strategies that are utilised when this behaviour is demonstrated. This document clearly outlines the interventions to be utilised that are specific to the resident and the behaviours exhibited. Three files of residents with dementia demonstrate the assessment has been completed, and is supported by a 24 hour diversional therapy (DT) plan to support the resident and to mitigate any situations that may result in challenging behaviour. Training records demonstrate an education session on challenging behaviours has been provided to staff, with plans to repeat the session for those staff unable to attend the first session. The CNM confirms that staff have access to a RN who is a provider of non-violent crisis intervention training. The previous area for improvement has been addressed. |

##### **Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.6: Service Delivery/Interventions **(**HDS(C)S.2008:1.3.6)

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

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures are in place to ensure that residents are appropriately assessed and care is planned to meet the identified needs of the resident. Observed practice demonstrates the care is provided according to the documented care plan. There is evidence of referrals to external services, such as community mental health, community elder health, hospice, wound care nurse, dietitian, physiotherapist, and documentation in the progress notes once the resident has been seen by the service, in the eight clinical files reviewed. There is evidence recommendations for care is incorporated into the plan of care and services delivered.  Handover and communication processes are in place (supported by documentation). Two HCAs confirm their understanding of communication processes with the nursing staff, including their responsibilities for being aware of the plan of care and any issues to the residents that they are responsible for. One RN and the CNM confirm that unit meetings are held to discuss clinical decision and care planning for residents.  The CNM confirmed that the shift handover process provides staff with specific information about the residents and when required, references the progress notes, which alerts staff to read, prior to the provision of care. Handover is led by the RN, and provides an opportunity for clarification of care issues prior to providing care. |

##### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.7: Planned Activities **(**HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility employs a qualified diversional therapist (DT) who is supported by a team of six diversional therapy assistants. A documented diversional therapy calendar is sighted and includes a range of activities including visiting musicians, singing, church services, van outings, news reading, baking, games, and opportunities for individual activities. Recreational assessments are completed for all residents on admission as well as a social profile which identifies activities that the resident would like to have included in their plan of care. Participation in activities is voluntary, with participation documented and evaluated by the DT. The DT confirms that she regularly joins the van outings in order to assess the resident’s responsiveness to the outing. Residents are able to personalise their rooms, with it observed that they have televisions and radios. Recreational lounges provide access to pets, music, games, with large spaces available for activities. A number of activities are observed occurring throughout the facility. |

##### **Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.8: Evaluation **(**HDS(C)S.2008:1.3.8)

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

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Nursing documentation in use provides the opportunity to evaluate the care provided and specific interventions that have been implemented. Residents are assessed by their GP to determine the required frequency for ongoing assessment. All eight clinical files reviewed demonstrate that this process has occurred, and residents are confirmed as appropriate for three monthly reviews. Nursing staff review long term care plans six monthly, or earlier if there is a change in the condition of the resident. One RN interviewed confirms that she was provided with additional time to complete six monthly reviews as the process of migrating to the new documentation is undertaken. The CNM confirmed processes are in place to ensure that the GP is made aware of the requirements for three month reviews, with a RN confirming and observation of a calendar in the nursing station which identifies when these reviews are provided.  A review of eight clinical files demonstrate that residents have been assessed as requiring three monthly reviews, there is documentation in the progress notes by the GP, as well as any reviews that are undertaken by the community elder health team or geriatricians. Progress notes document when progress is not as expected, with GP visits occurring outside of the planned three monthly review process. Communication faxes with the GP’s are included in the residents’ files, with evidence of recommendations incorporated into the plan of care and evaluated as required. The CNM and two RNs describe the process of communication with the GP’s and the pharmacy as efficient and appropriate. Short term care plans are in use for identified specific issues, with clear timeframes for evaluation and review. |

##### **Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.12: Medicine Management **(**HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Talbot Park has access to South Canterbury DHB policies and procedures for all stages of medication management. A number of policies specific to Talbot Park are also available. Registered nurses, enrolled nurses, and those health care assistants who are involved in the process of medication management are required to complete specific medication competencies. This includes orientation to the specific policies and observed practice to ensure the competency is met. The CNM and one RN confirm that they have completed the competency and that there is a requirement to complete this every year. The CNM notifies staff when they are required to complete the competency assessment. (Sighted competencies that have been recently completed by RN staff). Medication management is included in the orientation programmes for staff as appropriate (as sighted in orientation booklets).  Pharmacy support services are provided by the pharmacy at nearby Timaru Hospital. Nursing staff are responsible for the ordering of medications. A pharmacist visits the facility twice yearly, but is also available by telephone and email at all times. Processes are in place for accessing medications after hours. The Nomad system is in place with policies and procedures to guide the use of this system, with supporting documentation. Medications are dispensed by the Timaru Hospital pharmacy, with each nurse in the first 24 hours responsible for ensuring that the medications in the pack reconciles with the documentation. Process are described by one RN should an error or omission be discovered.  Previous areas requiring improvement regarding faxing of medication charts and the monitoring of ambient medication room temperatures have been addressed.  Processes regarding the completion of medication rounds in a timely manner, the accurate documentation of medications when there has been delayed administration, and ensuring the appropriate level of detail of information regarding medication administration and quantitative stock counts, have been identified as requiring improvement. |

##### **Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)**

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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The process for faxing medication charts to the pharmacy have been reviewed, with a process introduced whereby the original medication chart is faxed, and the process of faxing already faxed documents has ceased. When a GP makes a modification to the drug chart by fax, the faxed copy is removed once the GP has updated the original document. This has helped remove any issues with the quality of the information being faxed. A review of the medication charts for one wing demonstrates that only original documents are held in the folder, with faxed copies archived to the clinical record.   Process for monitoring of the ambient room temperatures in the two medication rooms are in place, with the CNM confirming that the night RN is responsible for ensuring this process is completed. The temperature is documented in a notebook, kept in the medication rooms. A review of the notebook demonstrates that the temperature is recorded daily as required. Previous areas for improvement have been addressed.  Policies and procedures are sighted that cover the medication administration process at Talbot Park. The Nomad medication administration process is in place and observed at the time of audit. Medication rounds are undertaken by the RN, with all medications dispensed from the Nomad packs or stock held within a locked medication trolley. At times, when this round coincides with a GP review round, other staff are available to support this process, such as the CNM. An 8 am medication round is observed to be still underway at 9.40 am. A review of two medication charts for whom medications are dispensed at 9.40 am demonstrates that these medications have been signed as being given at 8 am. |
| **Finding:** |
| An 8 am medication round is observed to be still underway at 9.40 am. A review of two resident's medication charts for whom medications are dispensed for at 9.40 am documents that these medications have been signed as being given at 8 am. |
| **Corrective Action:** |
| Adequate staffing is available and processes in place to ensure medication rounds are completed within the expected timeframes. Ensure that the correct time of medication administration is documented in the medication chart. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)**

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Policies and procedures for medication management are in place, including sighted policies that are specific to Talbot Park. The Nomad system is in use and has the appropriate accompanying documentation which clearly outlines the prescription and administration of medications. Specimen signatures for all staff involved in the medication management process are documented (observed). This previous area for improvement has been addressed.  A review of the controlled drug book demonstrates that weekly drug checks are occurring; however the process of quantity stock checks is not evident. The CNM confirms that stock counts are undertaken with the pharmacist six monthly, however this is not clearly documented.  Ten medication charts are reviewed and demonstrate inconsistency in the level of detail in the recording of information, including the recording of allergy status. Drug allergy alert stickers are in use; however, only one of three charts where an allergy has been identified has the sticker attached. The indications for the administration of PRN medications are not consistently documented in four medication charts, with four medication charts demonstrating that prescriptions dates are being bracketed. |
| **Finding:** |
| Four medication charts do not have indications for PRN medications documented; four charts have bracketing of dates for medications; two charts do not have the allergy status documented; and one of three charts where a drug allergy is identified has used the additional drug allergy alert sticker.  The controlled drug register demonstrates that ‘end of the page stock counts’ are occurring, however there is no evidence that 6 monthly quantity stock checks are occurring as required. |
| **Corrective Action:** |
| Ensure the medication charts are completed and quantity stock checks are undertaken as per the legislated requirements |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.13: Nutrition, Safe Food, And Fluid Management **(**HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Policies and procedures are in place to guide the management of nutrition for the residents. There is evidence of nutritional assessments being undertaken, and input from the dietitian. When required, nutritional supplements are prescribed and provided. Meals are based on self-select menus and provided on individual resident’s trays. Likes and dislikes are documented, with previous processes improved to include greater access to high protein snacks, and additional food at morning and afternoon tea. Food intake is monitored at each meal. All residents are weighed and referred to the dietitian when weight is being lost or there is a requirement to reduce weight. A previous area for improvement has been addressed.   Meals are delivered in trolleys that have been transported from the nearby DHB hospital, with it reported that these trolleys are heated prior to transport. A relative reported that food is not always as hot as it should be. A meal service is observed with staff available to assist residents with special needs or support with meals. A policy or process for the monitoring of the temperature of food when it is delivered is not in place and requires improvement. |

##### **Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Food is delivered in trolleys from the nearby Timaru Hospital. Trolleys are heated until loaded into the transport truck. Meals are delivered as individual trays based on self-selection of food. Currently there are no processes or policies in place for the monitoring of food temperatures. One relative stated that food is not always as hot as it should be. |
| **Finding:** |
| The temperature of food on delivery from the central kitchen at the nearby DHB hospital is not routinely monitored or recorded. |
| **Corrective Action:** |
| Develop a policy and process to ensure that the temperature of food is monitored and recorded. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **Outcome 1.4: Safe and Appropriate Environment**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

#### Standard 1.4.2: Facility Specifications **(**HDS(C)S.2008:1.4.2)

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

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The building has a current building warrant of fitness that expires 11 December 2014. There have been renovations undertaken in a small kitchen area, however this is primarily cosmetic and does not require comment in criteria 1.4.2.1 or 1.4.7.3.   A tour of the facility is undertaken and although not a scheduled component of the surveillance audit there is evidence of the need for significant changes to equipment and to the environment to ensure the safety of staff and residents and this is identified as an area requiring improvement. There is evidence of deteriorating paintwork, rusty appearing heaters, an open shower drain, and equipment in a state of disrepair, an accumulation of dirt on equipment and in service areas. Hallways and resident areas are cluttered and the lounge area of the dementia wing is clinical rather than ‘homelike’. |

##### **Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)**

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)**

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| A tour of the facility reveals that it is cluttered throughout with items spilling into the hallways in places and doors open to empty rooms filled with equipment of all types; some of which is surplus to requirements. There are service areas such as sluice rooms that are unclean, as well as being cluttered. Equipment sighted, including residents’ wheelchairs, are very dirty, some items such as shower chairs and linen bag covers are in need of repair, not all linen bags have covers and one staff person suggested there is a lack of equipment. There are areas where paint is peeling off walls and water heaters, a shower drain hole is open and flooring broken down, some heaters appear rusty and wall linings in shower areas are in deteriorating condition. The dementia wing, especially the lounge, is a clinical, rather than a ‘homelike’ environment.  The temporary manager informs she undertook a walk through with a facilities person from the SCDHB the previous week and is awaiting quotes for the work. An e-mail confirming this is sighted. |
| **Finding:** |
| There is potential health and safety risks associated with equipment being stored inappropriately, equipment being in a state of disrepair, deteriorating wall linings and paintwork, an open drain and a general state of unclean service areas and equipment. The dementia wing is a clinical environment for such a facility in 2014. |
| **Corrective Action:** |
| The state of the physical environment and equipment is reviewed and actions taken to ensure all areas minimise risk of harm to residents and to staff and to ensure it is appropriate to meet the needs of the residents. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

# NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

#### Standard 2.1.1: Restraint minimisation **(**HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The SCDHB policies and procedures for restraint minimisation and safe practise have been reviewed and are relevant for Talbot Park. The use of enablers is voluntary and residents are involved in approving and signing for their ongoing use at the time of their review. This is evident in the personal records of two people who use enablers. According to the register three people use enablers and these are all bed rails. Four hospital aides inform during interview that they know that enablers are voluntary. The evidence supplied addresses the previously raised required improvement that the use of enablers is voluntary and reflects the residents’ wishes. |

##### **Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

#### Standard 2.2.1: Restraint approval and processes **(**HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
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#### Standard 2.2.2: Assessment **(**HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The clinical nurse manager informs that the assessment form for the use of restraints has been reviewed. This is sighted and it is noted that all requirements of the standard are now included on the assessment form. Two residents’ files of people who use restraints are reviewed and demonstrate that all factors have been taken into account when assessing for restraint use. Consent for its use was signed on the date of the assessment. The restraint register shows three people have consents on file for the use of restraint in the Otipua wing and the clinical nurse manager informs that these people seldom require them. This is verified in the log. Four people in the Watlington wing dementia service have consents in place and these are reportedly used frequently for one person, less frequently for two and one other person seldom requires it and may be removed from the register at the next review. The implementation of the full assessment process addresses issues raised that were identified as requiring improvement at the certification audit. |

##### **Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)**

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:  
(a) Any risks related to the use of restraint;  
(b) Any underlying causes for the relevant behaviour or condition if known;  
(c) Existing advance directives the consumer may have made;  
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;  
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;  
(f) Maintaining culturally safe practice;  
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);  
(h) Possible alternative intervention/strategies.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 2.2.4: Evaluation **(**HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The nurse manager informs that the review process for restraint use has been revisited and the documentation for the evaluation of restraint use now requires consideration of all factors as listed in the standard (a) to (k). The evaluation of restraint use is undertaken in consultation with family members/Enduring Power of Attorney (EPOA) on behalf of the residents, as all people using restraint in this facility have dementia. The inclusion of all requirements of the standard and consultation with the relative/EPOA addresses the required improvement identified at the certification audit. Monthly evaluation forms are in place and are being used and restraint monitoring forms are being filled in.   Prior to the arrival of the previous temporary manager, there was a restraint committee that operated as part of the role of the previous operations committee. The temporary manager had oversight of restraint use alongside the restraint coordinator, who is the clinical nurse manager. An audit of restraint use for quality review purposes is occurring at three monthly intervals and results show there have been 122 episodes of restraint and 279 of enablers. There have not been any new applications for restraint or enabler use since the restraint committee disbanded. The restraint coordinator is maintaining responsibility for the use of restraints and reports of restraint use are in the weekly staff meeting minutes. |

##### **Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)**

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:  
(a) Future options to avoid the use of restraint;  
(b) Whether the consumer's service delivery plan (or crisis plan) was followed;  
(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);  
(d) Whether the desired outcome was achieved;  
(e) Whether the restraint was the least restrictive option to achieve the desired outcome;  
(f) The duration of the restraint episode and whether this was for the least amount of time required;  
(g) The impact the restraint had on the consumer;  
(h) Whether appropriate advocacy/support was provided or facilitated;  
(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;  
(j) Whether the service's policies and procedures were followed;  
(k) Any suggested changes or additions required to the restraint education for service providers.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

# NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

#### Standard 3.2: Implementing the infection control programme **(**HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Infection control processes are guided by policies and procedures which are available in hard copy throughout the facility. Two RNs confirm their understanding of the infection control programme, including the surveillance of infections and audit activities that are undertaken. Infection control is included in the orientation programmes for all staff. There is no evidence that the infection control committee has been active or meeting since August 2012 (confirmed by CNM). Whilst the 2013/2014 quality plan outlines key performance indicators for infection control regarding the surveillance of infections, and there is evidence that this information is being collected, analysed and reported, there is no evidence that the infection control programme has been updated since July 2012, and this is an area requiring improvement. |

##### **Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)**

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The responsibility for infection control has passed to the Clinical Nurse Manager (CNM) within the previous month. The CNM is booked to attend an education programme specific for registered nurses and infection control management (confirmation sighted) in October 2014. In the absence of formal education and orientation to the role the CNM clearly articulates her response and responsibilities in relation to an incident with body fluid exposure by a resident with hepatitis C. She confirms linkages with the Timaru Hospital based infection control team and microbiologists. There is evidence that an infection control audit was completed in February 2014 prior to the resignation of the previous CNM. Two RNs confirm an understanding of the infection control processes and that the CNM had recently taken over management of the infection control programme within the facility.  The previous survey corrective action with regard to development of a professional development plan for the members of the infection control committee has yet to be addressed as there is no evidence that the infection control committee has met since August 2012, and has in fact disbanded (as confirmed by the CNM). The infection control programme has not been updated since July 2012. This is an area requiring improvement |
| **Finding:** |
| Meeting minutes indicate that the infection control committee has not been active since August 2012. The Infection Control Programme/Plan has not been updated since July 2102. The CNM confirms that she has not received any formal orientation to the infection control role, nor holds a position description that clearly outlines the roles and responsibilities of this position. |
| **Corrective Action:** |
| Ensure the Infection Control Committee is re-established, the CNM is formally orientated to the infection control role, and processes are put in place to update the infection control programme and action plan for ongoing infection control activities including clinical and environmental audits |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 3.5: Surveillance **(**HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures are in place to direct facility specific surveillance activities. Key performance indicators within the 2013-2014 Quality Plan include the surveillance and reporting on: respiratory infections; urinary tract infections; ear, nose, mouth and throat infections; skin and soft tissue infections; and gastrointestinal infections. The reporting system determines the criteria to indicate an infection to be reported. Information is entered into a data base by the Clinical Nurse Manager (CNM) who has recently taken on the infection control portfolio. Monthly reports are generated and discussed at operational and ward unit meetings - three months of reports are sighted. The CNM confirms the copies of all infection reporting forms are sent to the DHB infection control nurse specialist who collates reports and analyses the data. Information is provided back to Talbot Park. One RN confirms the process of using the ‘yellow form’ and the type of infections that are to be reported. |

##### **Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |