

South Canterbury District Health Board - Talbot Park

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	South Canterbury District Health Board
Premises audited:	Talbot Park
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric)
Dates of audit:	Start date: 15 December 2014 End date: 15 December 2014
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	56

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Talbot Park is situated in Timaru and provides residential care for up to 67 residents who require hospital and psycho-geriatric level care and for younger people with a disability. Occupancy on the day of the audit was 56 residents; 34 receiving hospital level care; and 22 psycho-geriatric care and three younger persons with a disability. The facility is owned by the South Canterbury District Health Board. Changes in management have resulted in an improvement in most areas identified at the previous audit.

Thirteen of the previous twenty one required improvements have been addressed. Areas outstanding and new areas identified as a result of this audit relate to: quality improvement meetings; evaluation of data; monitoring of risks; resident and family involvement in care planning; evaluation and review of activity plans; medication management; food temperatures and facility repairs.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and family reported that staff communicated in an effective manner and there was evidence in documentation reviewed that open disclosure occurs.

There was now an easily accessed complaints process and register as part of the facility's complaints process, meeting two previous required improvements. Those complaints reviewed have been documented with actions completed, and all reviewed have been resolved.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The vision, goals and scope of the organisation were now included in the quality and risk management plan for the facility, addressing a previous required action.

There has been recent appointments of a facility and services manager and clinical nurse manager, and while significant improvement have occurred in collecting and analysing quality data, there was no formal meeting process to ensure quality management activities are evaluated; this still requires improvement. A quality and risk management system, current policies and procedures, and a document control system were now current and in place addressing requirements from the previous audit.

Incidents, restraint, health and safety, infection control, internal audits, family surveys and complaints feedback were now occurring, but it was still too early for evaluation of these to occur and this still needs addressing.

A hazard register was in place with appropriate risk ratings identified to ensure adequate controls; however, there was not a monitoring timeframe according to the level of the risk.

Review of staff records provided evidence that human resources processes were followed as required. This included individual employment agreements, job descriptions, police vetting, reference checks, and performance appraisals, meeting previous required improvements. A detailed induction and orientation was in place for all staff. There was evidence indicating an in-service education

programme was planned and provided for staff at least monthly, addressing a previous issue identified. Staff were also supported to complete the New Zealand Qualifications Authority Unit Standards relating to the care of older people, and first aid training.

Staff rosters showed there were adequate staff with the relevant experience and skills to cover all shifts.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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A range of nursing assessment tools was being completed and the outcomes contributed to the care planning process. Care plans were developed by registered nurses, and included personalised goals and interventions. In addition to three monthly clinical reviews, care plans were systematically reviewed by the clinical manager and nursing, medical and allied health professionals. A multidisciplinary team approach was used to ensure all of the assessed needs of residents were being met within safe timeframes. Short term care plans were used to evaluate and review progress with short term problems.

Activities were provided seven days a week by a team of staff with activities coordination and diversional therapy training and experience. Each resident had a comprehensive activities plan. The evaluation and review of service delivery plans was occurring, although evaluation of the level of achievement of goals in activities plans requires further development.

Medications were managed according to a suite of policies and procedures. Although shortcomings previously identified in medicine management have been addressed, several other gaps in the processes were evident.

Meals were provided from the local public hospital according to menus that have been reviewed by a dietitian. Personal preferences and personal dietary requirements were being accounted for. The loss of temperature of the food before residents receive it continues to be an area of concern.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The building has a current warrant of fitness. There have been no building alterations since the previous audit. There were still areas of disrepair that need addressing as identified in the previous audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures were in place. The service was using one restraint intermittently at the time of audit. Three residents had an enabler in place which was monitored and reviewed according to the organisation's processes.

Infection prevention and control

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

Standards applicable to this service fully attained.

The facility's clinical nurse manager was collecting monthly surveillance data and reporting to the infection control meeting every three months, addressing a previous required improvement. Infections were analysed and trends identified and processes put in place to minimise infections.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	12	0	5	1	0	0
Criteria	0	35	0	7	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Systems and entry documentation ensured residents and family members were advised on admission, and on-going, of the facility's complaints process, addressing a previous required improvement. Residents and family interviewed demonstrated an understanding and awareness of these processes.</p> <p>A complaints register was now in place at the facility and there were three complaints recorded in the last year. A review of two most recent complaints verified both have been resolved in a timely manner and now meet the requirements of Right 10 of the Code.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The facility's policy advocates that disclosure to the resident should be made when an adverse resident event has occurred. Typically disclosure should be within 24 hours of the event depending on the specific circumstances of the event. Two incident reports were reviewed and both verified that the facility had notified the resident's family within 24 hours of the incident, the treatment provided and a follow-up of when the resident was seen by the GP. The process was confirmed in the residents' hardcopy records.</p>

		<p>Interpreter and Translation Services were available should these services be needed. A policy document provided contact details for services. The policy also stated that those residents with hearing and visual deficits were to be accorded the degree of explanation or repetition necessary to establish recognition. Staff name badges were in large print for easier identification.</p> <p>The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) pamphlet provided to residents on admission, was displayed on walls, and available at the facility entrance. There was evidence in residents' files reviewed and during interviews that the staff communicate effectively with residents and their families at all times. Families reported that they were kept informed on issues relating to their family member.</p> <p>Staff were observed explaining and giving information to residents. Residents' meetings minutes reviewed demonstrate regular forums to enable residents to be informed, ask questions and discuss issues.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The facility is owned by the South Canterbury DHB. The general manager (GM) forms the link between the DHB and the facility. Reports were sighted that showed the communication relating to key indicators from the facility and services manager to the GM on a monthly basis. The facility and services manager and the clinical nurse manager form the leadership group of Talbot Park. While both have been in their roles for less than a year, they have had previous experience in aged care settings. They also relieved for each other when the other was on leave.</p> <p>There was now a quality plan for the facility that identified the purpose, scope, direction and values of the facility in line with the DHB overall philosophy, addressing a previous required improvement.</p> <p>The vision and goals have been reviewed in May 2014 and included detail of each goal and how these will be met by the facility and the expected outcomes.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that</p>	<p>PA Low</p>	<p>The organisation's quality policy and risk management plan, reviewed in May 2014, detailed the responsibilities for quality and management of the facility, meeting a previous area requiring improvement. There have also been improvements in the collection of data and reporting to the GM, however there is still not a link between quality improvement data at a facility level and this needs addressing. The facility</p>

<p>reflects continuous quality improvement principles.</p>		<p>and services manager and the clinical nurse manager reported that they have intentions of recommencing the operations group to run the quality improvement programme and discuss quality initiatives and indicator feedback in the New Year.</p> <p>There was documented evidence of feedback from residents, family and staff regularly throughout the year, including as formalised resident and family surveys and meetings; this is confirmed in interviews.</p> <p>A document control system was now in place to manage all documents, policies and procedures, and there was a policy manual for the facility, addressing previous required improvements. Obsolete documents were archived electronically and paper copies removed from circulation.</p> <p>A corrective action plan now addresses any area of non-conformity with Standards and requirements.</p> <p>The risk management register was sighted and included the type of risk, potential harm, risk and hazard rating, proposed treatment, completion and monitoring; however monitoring timeframes are not linked to the severity of the risk, requiring further action.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Adverse or untoward events were documented on a form specific for event reporting. The clinical nurse manager was responsible for collecting forms and she reported that she then discussed the content with the facility and services manager. Collated data was now being reported to the GM on a monthly basis, as sighted in the written reports.</p> <p>Adverse events reported included a range of incidents and accidents, including falls, skin tears and bruises, a range of infections (e.g., skin, respiratory, urinary tract infections). Non-clinical indicators included staff injuries and accidents, property, security or emergency incidents.</p> <p>The facility and services manager and the clinical nurse manager interviewed demonstrated they were familiar with essential notifications they must report to other authorities.</p> <p>Three completed incident forms were reviewed and all required actions were taken, including notification of families, GPs, as appropriate. All relevant corrective actions raised were communicated to staff in staff meetings reviewed, progress was tracked and preventative measures implemented.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There were policies and procedures covering all aspects relating to staff recruitment, induction and orientation, performance appraisals, training and competencies, and police vetting. Staff members and external personnel, such as general practitioners, working within a professional scope of practice have their qualifications verified to ensure there are no restrictions on their scope of practice. Staff files and documentation reviewed met all these recruitment and employment processes.</p> <p>A comprehensive annual training programme was in place. Staff reported that training is scheduled at least monthly and they are supported and encouraged by management to attend these sessions. The folder sighted included the sessions, content and the number of staff who have attended.</p> <p>A review of the roster verified that at least one staff member on each shift was trained in first aid, and the facility and services manager reported the aim was for all care staff to be trained in first aid.</p> <p>There were a number of modules that were compulsory for all staff and this included training about the Code, infection prevention and control, manual handling, non-violent intervention, complaints and informed consent. All care staff must complete the 'Careerforce' aged care training and the education registered nurse manages this programme. Of the files reviewed all staff had commenced, or had been trained on this level. Staff working in the psycho-geriatric unit have undertaken the relevant module of the 'Careerforce' programme with some also having attended specialist courses such as 'Spark of Life' and 'Walking in Another's Shoes'.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy document sighted guides staff hours, roster, and staff skill mix. This described the process for rostering, staff designations and hours that are set according to the needs of the individual resident and full occupancy. The facility does not reduce staff if the bed occupancy is reduced. Staff hours were set to ensure that they were sufficient staff to provide safe care in a timely manner. This took into account the dependency levels and time required to provide care according to the individual's care plans.</p> <p>All rosters are maintained by the facility and services manager and were prepared</p>

		<p>in advance using the organisation's roster tool.</p> <p>The rosters were sighted for the current two weeks and these confirmed adequate cover for the needs of the current residents. The clinical nurse manager reported that any absences were covered internally as there was a number of 'casuals' able to be called on.</p> <p>Staff, residents and family members reported there were sufficient staff on all shifts.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Medicine management policies and procedures were available and were consistent with legislation and accepted protocols and guidelines. Registered nurses affirmed they are responsible for all medicine management processes and work alongside the pharmacy department of Timaru hospital. The timing of the administration of morning medicines was raised as an area for correction at the last audit and this has been addressed by ensuring two registered nurses are now on duty first thing in the morning. Previously noted shortcomings in the medicine record sheets around pro re nata medicines needing indications for use, the bracketing of medicines with one signature and not all residents having a record of their allergy status, were no longer evident. Likewise, the pharmacy is now checking controlled drug counts.</p> <p>Medicines were safely locked away and a lockable medicine trolley was used during an observed medicine round. Controlled medicines were being double checked at the time of administration with supplies checked by two staff with a medication competency, on a weekly basis. Medicines were being administered by staff with a medicine administration competency and safe administration practices were observed during a mid-day medicine round.</p> <p>Three monthly reviews were evident on medicine charts, which were being filled in according to requirements and had discontinued medicines crossed through, signed and dated. The pharmacist delivers the medicines on a weekly basis and dispenses the medicines into packaging according to the prescriptions.</p> <p>Medicines were being signed for when administered. Medicine management systems are being reviewed as part of the internal audit review processes.</p> <p>There were some areas of medicine management that require attention. These relate to the need for standing orders to be reviewed, ensuring fax medicine records are signed by the GHP within 48 hours, obtaining sample signatures for GPs and</p>

		the implementation of reconciliation processes.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	PA Low	<p>The menu has a three week rotating cycle and has winter and summer options. It has been reviewed by a dietitian from the local hospital. A nutritional profile was completed for each resident on admission and this was updated as required. All reviewed residents' files had a nutritional profile that covered personal preferences, food allergies and any special needs such as soft foods or puree food.</p> <p>Nutritional assessments have been undertaken by a dietitian when identified as necessary, such as when there was evidence of weight loss in monthly weight records. Dietary modifications were made accordingly.</p> <p>The clinical nurse manager informed she was responsible for ensuring the kitchen received updated menu sheets, which included any feeding equipment, on a daily basis. The profiles and menu sheets were used to ensure all special dietary requirements were met.</p> <p>Food for the main meals is transported from the South Canterbury DHB Timaru Hospital. Sandwiches, fruit and baking was available to residents outside of these timeframes. The temperature of hot food was taken before it leaves the hospital and was rechecked and recorded on arrival at Talbot Park. Talbot Park needs to ensure food temperatures are warm enough for residents by the time they get to eat it.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The care plans demonstrated 'head to toe' nursing assessments were being completed on admission. Specific assessments for a range of issues, such as continence, pain, mobility, falls risk, skin integrity and cognition, for example, were also evident in residents' files. When indicated, these were repeated prior to six monthly reviews and as necessary. The information obtained was being used to help develop goals and objectives for the care plans. These processes addressed an area that was not meeting the standard at the last audit.</p> <p>Family involvement was reportedly encouraged and family members were observed to be assisting during the audit. The documentation does not necessarily reflect their involvement in service delivery planning and review, which is raised as an area that requires action.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>According to residents' files reviewed and to family and residents who were interviewed, services were meeting the needs of residents, as documented in the service delivery plans. Service delivery plans were based on assessment and review processes. Family involvement was reportedly encouraged and family members were observed to be assisting during the audit.</p> <p>Although residents reported their desired outcomes were being met, it is not possible to assess the level of this as the documentation sighted does not necessarily reflect their involvement in service delivery planning and review, or that of family members.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Residents and staff reported that Talbot Park provided a comprehensive range of activities. This was also evident in examples of monthly activity plans that were provided. The choices within the programme were broad with options of a cognitive, physical, social, cultural, environmental, spiritual and fun nature. A diversional therapist oversees the activity programme that was delivered by a trainee diversional therapist and activities coordinators over seven days of the week. Activities were provided in both the hospital and psycho-geriatric services and the needs of individuals, as well as the different resident groups, have been considered. There was evidence that people were kept occupied outside of formal group activity timeframes.</p> <p>Each resident had a personal profile about their personal interests, culture and family and an activity plan with eight to nine activity goals. Activity plans included a rationale for each goal, objectives and interventions. All were signed and dated. As noted in criterion 1.3.8.2, there is a need for improved evaluation of the goals within these plans.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Personal goals in residents' nursing care plans sighted had been reviewed every six months. The reviews were dated and showed that the goals and objectives in each section of the care plans had been evaluated according to the degree of achievement of each goal. Relevant changes in the level of intervention(s) were evident and objectives were amended when changes in a resident's condition had occurred. Assessments, with use of assessment tools, were being repeated prior to</p>

		<p>reviews of service delivery plans and the outcomes contribute to the evaluations.</p> <p>Activity records in residents' personal files included comprehensive sets of individualised goals; however, these were not currently being evaluated.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>The building warrant of fitness (BWOFF) was sighted and expires on 1 December 2015. There have been no changes to the building since the previous audit.</p> <p>The exposed drain has now been repaired and there were plans to address the disrepair throughout the facility; however, this required improvement remains open as the work has not been approved or commenced.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The clinical nurse manager was the infection control co-ordinator and records showed she had relevant training to manage the role. An infection control meeting was observed and records reviewed showed these occurred three monthly and covered all infection control requirements. The facility has access to a microbiologist as required, as well as the residents' GPs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The clinical nurse manager collects monthly infection control forms and transfers the information onto monthly report sheets listing specific infections of urinary tract, skin and wound, eye, respiratory tract, skin and wound and gastro-enteritis infections. This provided an up to date analyses of trends and patterns.</p> <p>Documentation sighted included the collection, collation and analysis of information on infections and the measurement of incidence and recommendations for minimising infections.</p> <p>Evidence in the last two reports to the GM and staff meeting minutes verify that infection control surveillance, analyses, conclusions and specific recommendations to minimise reduction in infection have been documented and reported to the facility and the organisation.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is</p>	FA	<p>The facility had policies, procedures and forms in relation to the use of restraints and enablers. There was a definition of restraint and enabler use consistent with the</p>

<p>actively minimised.</p>		<p>standards. There was a clear guide to follow before any restraint was considered, and a consent process for residents and family or enduring power of attorney (EPOA).</p> <p>The clinical nurse manager was the restraint coordinator and consulted on all restraints with the GP and facility and services manager, as sighted in records reviewed.</p> <p>At the time of the audit three enablers were being used and intermittent use of one restraint. Regular monitoring was undertaken and records of these sighted as being completed as required.</p> <p>There was a current restraint register with the three current enablers (bedrails) which were in use for safety reasons. This included a 'key' for the purpose of the enabler; whether the person was at risk of falls, a risk to themselves or a risk to others.</p> <p>Education was provided to all staff as a compulsory module at orientation and included reading the restraint and enabler policies and procedures. In-service education was part of the annual training schedule.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	PA Low	<p>There is evidence that quality improvement data was collected on a regular basis. Documentation included a written report to the GM monthly with detail of key components and outcomes. Staff meetings include health and safety and infection control (IC), but did not include complaints, clinical incidents, and restraint or survey/feedback findings. The facility and services manager reports that the operations meetings will recommence in early 2015 to address this.</p>	<p>There was not a specific link between all quality improvement data at a facility level in a quality management meeting forum.</p>	<p>All quality improvement data is linked to the quality management system.</p> <p>180 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and</p>	PA Low	<p>There has been a noticed improvement in the collection and analyses of quality improvement data over the past two</p>	<p>Quality improvement data was collected and analysed, but had not yet been analysed nor results reported</p>	<p>Quality improvement data is collected, analysed and</p>

evaluated and the results communicated to service providers and, where appropriate, consumers.		months. Documentation was sighted of incident reporting, complaints management, infection control and event reporting, being collected and analysed. However it is still too early for evaluation of this data.	to service providers and consumers as appropriate.	evaluated. 180 days
<p>Criterion 1.2.3.9</p> <p>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:</p> <p>(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;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Low	The FSM during interview reports that she oversees the input of all risks in the facility's hazard register. There are documented all potential and actual risks for all service areas and environment. These were specific to each area and reviewed regularly as new risks were identified. The timeframe for review of the risks was not based on the severity of the risk.	The monitoring timeframe for all risks was on-going, rather than a timeframe determined by the severity of the risk.	<p>Identified risks are reviewed at a frequency determined by the severity of the risk.</p> <p>180 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and</p>	PA Moderate	Registered nurses oversee medicine management and procedures are described with policy documents. Folders of medicine records included sets of standing orders in the psycho-geriatric unit and one for each of the two wings in the hospital area. It is now more than twelve months since the standing	Not all aspects of medicine management were in line with medicine-related guidelines and legislative requirements, in particular the use of outdated standing orders; the administration of medicines off fax sheets; the need for sample signatures of GPs prescribing	Medicine management complies with relevant legislation, protocols and guidelines.

<p>medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>orders were last reviewed. The clinical nurse manager advised that efforts to have these reviewed were thwarted by a person becoming unwell.</p> <p>Medicine records were in an orderly state with each resident having a photograph identification all prescriptions were signed and dated and there was evidence of three monthly reviews. However, there was evidence of medicines being administered off faxed medicine records that were more than 48 hours old.</p> <p>The clinical manager informed she undertakes medicine competency reviews with all staff responsible for medicine administration and records of these were viewed. Nurses and healthcare assistants who have medicine administration competencies had sample signatures on files but there were no sample signatures for GPs prescribing medicines.</p> <p>Pharmacy staff from Timaru hospital deliver medicines weekly. A registered nurse described how medicines for new residents are checked when they enter the facility and the GP enters current medicines into a medicine record. There was no documentation to demonstrate reconciliation processes for the arrival of medicines into the facility from the pharmacy.</p>	<p>medicines and the need for medicine reconciliation processes.</p>	<p>90 days</p>
<p>Criterion 1.3.13.5</p>	<p>PA Low</p>	<p>Main meals come from the SCDHB</p>	<p>Hot foods were being provided to</p>	<p>Food is transported</p>

<p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>		<p>Timaru Hospital. They are transported on covered trays in mobile food tray wagons from the hospital kitchen. These are not heated so heat is hard to retain and the wagons have panels in the rear that are bulging and contributing to heat loss. Temperatures of food on arrival at Talbot Park were being taken, however this was inconsistent. Temperature records sighted were as low as 55 and 58 degrees prior to the trays being distributed. The trays then need to be handed out to the residents and the person prepared for eating the meal or to be assisted. This was an issue identified as requiring improvement at the last audit and continues to be an issue. These systems are not ensuring that food is warm by the time it reaches the residents to eat.</p>	<p>residents at temperatures below that required. Food temperatures were not always checked daily and those on record were as low as 55 and 58 degrees Celsius. The food trolley had gaping panels in the rear, which was contributing to heat loss. The systems in place do not ensure food is warm by the time it reaches the residents.</p>	<p>and managed in a way that will ensure the temperature of hot food is within recommended guidelines.</p> <p>180 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Service provision was consistent with assessed needs. There was limited evidence that desired outcomes were being fulfilled as residents were not formally consulted about what they wanted as outcomes. Likewise, although family visits were encouraged and there was open communication occurring, there was no evidence that family members were contributing to care planning, to ensure the desired outcomes of their family member were fulfilled.</p>	<p>It was not possible to know if desired outcomes are addressed in the provision of services as neither residents, or family members, are formally involved in the care planning process, as required in section D16.3 (f) of the Aged Related Residential Care Agreement.</p>	<p>Residents and family members are involved in the care planning process to ensure that desired outcomes are met.</p> <p>180 days</p>

<p>Criterion 1.3.8.2</p> <p>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.</p>	<p>PA Low</p>	<p>Evaluations of care plans were occurring and indicated the degree of achievement of individualised goals. Changes were evident in the nursing care plan when indicated. A diversional therapist was responsible for the development of individualised activity goals for residents and for the evaluation of the activity plan goals. However, this person is not involved in the actual delivery of activities and was dependent on other staff to keep her informed. There was a lack of evidence that the degree of achievement of the goals within the activity section of residents' service delivery plans was being considered and nor was there evidence of changes made to the intervention sections of the activity plans.</p>	<p>The review of individualised goals within the activity plans did not show evidence of evaluation of the degree of achievement of individualised activity related goals.</p>	<p>Reviews of residents' activity plans require evaluation of the degree of achievement towards individualised goals.</p> <p>180 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>The facility is clean and tidy. There were areas throughout that were in a state of disrepair and wall linings are deteriorating. A plan was reviewed that documents all areas identified, with costing and timeframe to complete, however the repairs had not yet been approved or commenced.</p>	<p>There were areas in a state of disrepair and deteriorating wall linings.</p>	<p>The physical environment is in a good state of repair and appropriate to the needs of the residents.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.