

South Canterbury District Health Board - Talbot Park

Introduction

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

The audit has been conducted by 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 July 2015 End date: 16 July 2015
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:	62

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 owned by the South Canterbury District Health Board (SCDHB) and provides hospital specialist dementia care services (25 beds) and hospital level continuing care services (42 beds). At the time of this certification audit there are 62 residents, including three under the age of 65 years. The service also has a contract to provide respite care for those under 65 years of age. The SCDHB has declared that they wish to cease providing services at Talbot Park and at the time of audit a planned process to explore the best approach to this is underway.

This certification audit was conducted against the Health and Disability Services Standards and the provider's contract with the SCDHB. The audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, family, management (including two managers from the DHB) and staff. A general practitioner and two visiting nurse specialist staff were also interviewed. All staff, families and residents interviewed expressed satisfaction with the services provided and spoke of the improvements made over the past year, in particular.

There is one area identified as requiring improvement relating to several environmental issues; these include testing of equipment, ensuring privacy in one of the bathrooms, and maintenance in the kitchen area in the Hunter wing.

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

Care provided to residents is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected.

Appropriate policies, procedures and community connections ensure culturally appropriate support can be provided.

Residents interviewed felt safe, there was no sign of harassment or discrimination, staff communicated effectively and residents were kept up to date with information. Residents, or their enduring power of attorney, sign a consent form on entry to the service with separate consents obtained for specific events.

The service informs residents and their families of how to access the Nationwide Health and Disability Advocacy Service and encourage residents to maintain connections with family, friends and their community and to access as many community opportunities as possible.

Any complaints are managed according to the SCDHB policy and process, which meets the requirements of the Code of Health and Disability Services Consumers' Rights. Those reviewed were managed in a timely and sensitive manner and were used to make improvements.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Talbot Park is managed by a suitably qualified and experienced facility service manager who is supported by a clinical nurse manager and assistant manager. According to the staff, residents and families interviewed the team work well together to provide care and services based on the needs of the residents. Residents and their relatives reported being very satisfied with the care and services provided.

Quality and risk management systems are well coordinated through the Continuous Quality Improvement Committee that includes family representation. There is effective and integrated monitoring of all service delivery areas. The service is managing health and safety and risk matters in accordance with current best practice and legislation, supported by the manager from the DHB. The event reporting system is well established and known by staff. Two more serious events reviewed demonstrated that the DHB required process is being followed. Examples of improvements to the service as a result of feedback from staff, families, audit results and other quality related data was evident.

Recruitment, selection and management of staff meets the requirements of these standards, legislation and good practice. All staff attend regular ongoing education and training in subject areas that are specific to the residents being cared for. Training has been a focus over the past year and all staff working in the specialist care unit either have, or are working towards, the required qualifications.

There are sufficient numbers of suitably qualified and experienced staff on site 24 hours a day seven days a week.

Residents' information was accurately recorded, and all information was securely stored and not accessible to the public. Service providers use up to date and relevant residents' records.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Information packs and web sites contain information on the service's entry criteria, fees payable, service inclusions/exclusions and residents' rights. The organisation works closely with the Needs Assessment Coordination Service to ensure access to the service is efficient, whenever there is a vacancy.

Residents' needs are assessed on admission by the multidisciplinary team. All residents' files sighted provided evidence that needs, goals and outcomes were identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved, and that the care provided was of a high standard.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted were consistent with these documents.

Food services are provided from the SCDHB kitchen and meet the needs of the residents. Improvements have been made to ensure the temperatures of the food arriving from the hospital are maintained. A dietitian visits the service on a two weekly basis and special dietary needs are met. Staff provide assistance and support to those who require this to ensure nutrition and fluid requirements are met. Residents' weights are monitored.

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 facility is divided into three separate resident areas, one of which is the secure specialist dementia area. There are a mix of single and double rooms of varying sizes. All have sufficient space, are personalised to the individual resident's taste and are safe. Several lounges and dining areas allow for residents and their families to relax, dine and carry out recreational activities. Improvements in seating to better meet the needs of individual residents have been made. External areas are available for sitting and shading is provided. Residents in the dementia care area are provided with an internal and external environment that meets their needs. Residents and families were satisfied with the environment.

The preventative and reactive maintenance programme includes equipment and electrical checks, however not all equipment is being included in the functional testing system and there is no inventory list to ensure that all electrical equipment is included. The facility has a current building warrant of fitness. A kitchen area in the Hunter wing needs maintenance to ensure that it meets food safety hygiene requirements.

Adequate numbers of showers and toilets are easily accessible in all areas. One showering area needs review to ensure that auditory privacy can be assured.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely managed and stored. All laundry is washed off site at the Timaru Hospital. Cleaning services are an externally contracted service which is well integrated and meets the needs of Talbot Park. The facility was clean on the days of the audit.

Emergency and disaster planning is managed as part of the DHB programme. Staff have been trained in evacuation and other emergency procedures. An appropriate call bell system is available and security systems are in place. The facility was warm and well ventilated.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation is committed to using the least restrictive environment and equipment to maintain safety and independence. On the days of audit there was one resident using a restraint and one resident using an enabler. The specialist dementia area is a secured environment. The methods used for assessment, consent and approval, monitoring, evaluation and review meet the requirements of the Restraint Minimisation and Safe Practice Standards. The service has succeeded in reducing the number of restraint interventions over the past year. Staff have had training and were confident in their ability to manage the approved restraints and enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The service provides an environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined with the infection control coordinator reporting directly to the facility manager who reports to the owner.

There is an infection prevention and control programme for which external advice and support was sought; this is reviewed annually. An infection control nurse is responsible for this programme, including education and surveillance.

Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections was occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated and analysed. The results of surveillance are reported through all levels of the organisation, including governance.

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	49	0	1	0	0	0
Criteria	0	100	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Interviews with residents (six hospital) and family members (six hospital and four specialist psycho-geriatric services) of residents in both the hospital and specialist psycho-geriatric service verified services provided complied with consumer rights legislation.</p> <p>Policy documents, staff orientation programme, in-service training records, education programmes, interviews with staff, and satisfaction surveys verified staff's knowledge of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Clinical staff were observed to explain procedures, seek verbal acknowledgement for a procedure to proceed, protect residents' privacy, and address residents by their preferred name.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed</p>	FA	<p>The informed consent policy describes all procedures to ensure the residents' rights to be informed of all procedures undertaken.</p> <p>Documentation, observation and interviews evidence information is provided to make informed choices. Informed consent is understood</p>

<p>choices and give informed consent.</p>		<p>and is included in the admission process. The resident, and where desired family/whanau, are informed of changes in the resident's condition and care needs, including medication changes. Residents' choices and decisions, including advanced directives, are recorded and acted on where valid.</p>
<p>Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>The service recognised and facilitated the rights of residents and their family/whanau to advocacy/support by persons of their choice. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilised appropriate community resources, both internally and externally. Residents and their families are aware of their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations, with the support of the service. The service acknowledged values and encouraged the involvement of families/whanau in the provision of care, and the activities programme actively supports community involvement.</p>
<p>Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints process, as defined in the DHB wide policy, is well established across the organisation and meets legislative requirements. Residents and their families have a variety of mechanisms to make a complaint and those interviewed knew how to do so. Complaints management is explained during the admission process, supporting information provided as part of the admission package. 'I-forms' are clearly visible and information posters on how to make a complaint are displayed around the facility. The home page of the hospital website also has an email address for residents to use to give feedback. The facility and services manager (FSM) spoken with described the complaints management process and a registered nurse (RN) and health care assistant (HCA) interviewed were familiar with the</p>

		<p>process and how to access advocacy services.</p> <p>All four complaints received since January 2014 were reviewed and showed timely and sensitive management to resolution. The necessary details were recorded in the complaints register reviewed. Response timeframes, numbers and types of complaints are monitored and reported by the FSM to the Talbot Park Continuous Quality Improvement (CQI) Committee and as part of the DHB reporting processes. There have been no complaints received via the Health and Disability Commissioner (HDC) since the previous audit.</p> <p>Complaints are used to make improvements as identified in examples discussed with staff and managers.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Interviews, observations and documentation verified residents are informed of their rights. Information on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service is displayed and accessible to residents.</p> <p>Discussion, clarification and explanation on the Code and the Advocacy Service occurred at admission. Legal advice is able to be sought on the admission agreement or any aspect of the service. Information is provided on the facility's costs and range of services.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Policy identifies that procedures are in place to ensure residents are kept free from discrimination, harassment, abuse and neglect, including the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. Residents receive services which treat them with respect and has regard for their dignity, privacy (refer 1.4.2), sexuality, spirituality and independence.</p> <p>Staff demonstrated policy awareness and responsiveness to residents' needs.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Documentation is in place to guide staff practices to ensure residents' needs are met in a manner that respects and acknowledges their individual cultural values and beliefs. Policy states that this is to be identified upon entry as part of a resident's care planning process. The service recognises the relationship between iwi and the Crown and the principles of the Treaty of Waitangi (Partnership, Participation and Protection). Whanau relationships and involvement in care are recognised. The South Canterbury District Health Board's (SCDHB) Maori Health advisory group supports the needs of Maori residents at Talbot Park and will assist if required.</p> <p>Staff receive education in relation to cultural safety and the Treaty of Waitangi.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Policy identifies that residents receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values and beliefs. Evidence verified that residents do receive and are consulted on such culturally safe services.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Policy indicates that residents are to be free from all forms of discrimination, coercion, harassment and exploitations. Orientation/induction processes inform staff on the Code. The company's house rules, policies and procedures provide clear guidelines on professional boundaries and conduct, and inform staff about working within their professional boundaries.</p> <p>Interviews verified staff's understanding. Residents felt safe and received a high standard of support and assistance and reported there was no sign of harassment or discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages good practice. Policies sighted are current, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. Policies reflected current evidence based best practices, which are monitored and</p>

		<p>evaluated at organisational and facility level.</p> <p>Documentation, observation and interviews verified a range of opportunities is provided to enable staff to provide services of a high standard. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and responded appropriately to medical requests.</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>Policy identified that interpreter services are available and offered to residents with English as a second language. The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided. Communication with relatives is documented in the residents' communication records and incident forms and verified an environment conducive to effective communication.</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>	FA	<p>On 6 May 2015 the SCDHB announced its intention to cease providing aged residential care services provided at Talbot Park. Timeframes around a planned process on how best to cease service provision have been shared publicly, with meetings held with staff, residents and relatives. Timeframes and this process were discussed with two DHB general managers who reported that further information is to be presented to the next DHB Board meeting at the end of July. In the interim services continue as usual. At the time of audit all of the 25 specialist dementia care beds were occupied (Wattlington) and 37 of the 42 continuing care hospital level beds were occupied. These are divided into two areas (Otipua wing with 32 beds and Hunter wing with 10 beds).</p> <p>Talbot Park is part of the SCDHB planning process and, in addition, has developed their own Quality and Risk Plan (2015-2016) which defines specific and relevant goals. Reporting requirements are in line with the DHB requirements and the facility and services manager FSM, who currently reports to the GM Planning and Funding, discussed these. The written report from the Talbot Park clinical nurse manager (CNM) to the FSM reviewed showed key indicators and information</p>

		<p>reported to inform the next level of FSM reporting.</p> <p>The management team consists of the FSM, who has been in the role for the past year, the CNM and the assistant manager (AM), who oversees administrative and financial requirements. They all have the necessary experience and qualifications for their roles. The FSM has completed appropriate education relevant to the role. The job description of the FSM reviewed identified the authority, accountability and responsibility for the provision of services.</p> <p>Interviews with residents and family/whānau confirmed that their needs were being met by the service. This is supported by the 2014 satisfaction survey results sighted. Staff interviewed expressed confidence in the management team and reported improvements in systems and process over the past two years and in particular the last year.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The day to day operation of the service is overseen by the management team, with the clinical responsibilities delegated to the CNM. Reporting lines are defined and understood by those in the roles and staff reporting to them.</p> <p>During a temporary absence of the FSM the CNM covers this role, with support from the AM and the DHB roles as required. Both the FSM and CNM were clear about responsibilities of their roles.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Talbot Park has a quality and risk management system which is understood and implemented by service providers. This is documented in the Quality and Risk Plan 2015-2016. This includes the development and update of policies and procedures at organisational level, regular internal audits, incident and accident reporting, health and safety reporting, restraint, infection control data collection and complaints management. The audit programme reviewed covers a wide range of topics (21) and is responsive to issues arising. Audits reviewed were thorough and issues identified, which was the case in all those audits reviewed, were addressed through a corrective action planning process. The resident and family satisfaction survey, due for</p>

	<p>completion in June 2015, has been delayed, due to the current uncertainty of the service. The FSM reports that this will be completed in the near future. The 2014 survey reviewed demonstrated satisfaction with the service and the few issues raised have been addressed through a planned process.</p> <p>Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. The establishment of the Continuous Quality Improvement (CQI) Committee over the past year has improved consultation with residents and families, with resident and relatives represented on the Committee. Two relatives interviewed, who are on the Committee, discussed the benefits of this and improvements that had come about as a result of their raising issues in this forum. Minutes of the CQI Committee reviewed showed good attendance, a comprehensive standardised agenda providing a key link for quality improvement activities, data analysis, corrective action planning, and responsibilities and timeframes for actions. Staff on the Committee also reported this to be an effective forum. Reporting on CQI and risk management is also a requirement of the DHB and data reviewed demonstrated this reporting mechanism. A number of quality improvement projects were discussed with the management team, staff and families, and although some of these are in the early stages (eg, falls reduction), good progress is being made.</p> <p>Policies and procedures sighted are both DHB wide and Talbot Park wide. The document management system discussed with the FSM showed that policies are appropriate to the services provided, reviewed in a timely manner and referenced to appropriate resources, in most cases.</p> <p>Actual and potential risks are identified and documented in the DHB wide electronic hazard register. The review of three recently defined risks specific to Talbot Park related to the impending changes, were reviewed and discussed with the two DHB GMs and the Talbot Park FSM. This demonstrated a good understanding of the process and identification of appropriate controls and measures. Health and safety requirements, including a current Talbot Park hazard register, were discussed with the DHB health and safety manager. The DHB, including Talbot Park, has recently moved from primary level to secondary level in the ACC Workplace Safety Management</p>
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		<p>Programme (WSMP).</p> <p>Resident and families/whanau interviewed confirmed any concerns they have are addressed and they are satisfied with services delivered and improvements made. They report the manager has an 'open door' policy and this was evident during the course of the two day audit.</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>Policy identifies that all accidents, incidents and near misses must be recorded and reported to management accurately and within documented timeframes as identified in the flow chart procedure. For example, serious harm must be notified to management immediately and a 'near miss' must be logged electronically within 48 hours. The staff reporting process for incidents and accidents included the family/whānau being notified, to meet the principles of open disclosure. The described process is implemented at Talbot Park.</p> <p>Staff interviewed stated they report and record all incidents and accidents and that this information was shared at meetings and other staff forums, including any follow up actions required. The FSM, the CNM and staff confirmed that information gathered from review of incident and accidents was used as an opportunity to improve services where indicated and examples were discussed. A sample of incidents, including two more serious incidents (with severity assessment scores (SAC) ratings of 2) were reviewed and discussed with the FSM. One of these is in the process of review with the establishment of a root cause analysis group, with representatives from both Talbot Park and the DHB; the second example showed a review had occurred and recommendations were to be presented to the next CQI Committee meeting for sign off. A central log of corrective actions has recently been developed by the FSM and examples of these being signed off when completed were noted. Several other examples were yet to be signed off, but actions were either in progress or recently completed.</p> <p>The FSM and one representative from the DHB quality team were aware of essential notification and/or where to access information about this. An example of reporting to the Ministry of Business, Innovation and Employment was discussed.</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>Policies and procedures identify human resources management that reflects good employment practice and meets the requirements of legislation. Upon employment, referees are contacted and police vetting occurs. Prior to employment all requirements (including police vetting results) are required to be signed off by the GM planning and funding. Job descriptions described staff responsibilities. Although there has been a slight increase in the number of staff resigning over the past year, the majority of staff have been working at the service for a long time. A group of seven staff interviewed had worked at the facility for between 18 months and 30 years. Staff have completed a comprehensive orientation programme and two of the most recently employed staff interviewed (one RN and one HCA) reported feeling well supported and that this programme had prepared them for their roles. The two examples reviewed were fully signed off and dated.</p> <p>Staff undertake training and education related to their appointed roles. The education calendar is set at organisational level with additions specific to Talbot Park service provision. Staff education includes regular on site education with guest speakers, off-site seminars and training days and 'on line' topics to ensure all aspects of service provision are met. There has been an increased focus on staff development and training over the past year with two Careerforce assessors now on site. All HCAs employed in the dementia care area, are enrolled and progressing with the relevant Careerforce modules, as required, and those interviewed confirmed feeling well supported. Mandatory training requirements are defined and completion requirements are monitored. Life support training, which includes safe management of the environment and management of choking episodes, is completed at the DHB. Non-violent crisis intervention training is also a DHB wide programme and staff have completed requirements. Although staff in the dementia area stated this was useful and they felt confident in de-escalation techniques, the current programme is being reviewed to improve relevance to the setting. Four RNs have completed the interRAI assessment training and one is in the process of completing this. The CNM is in the process of completing the update requirements on line. Outstanding training requirements are followed up with individual staff and examples of this were noted on the</p>

		<p>staff room notice board. Training opportunities to improve attendance at non-mandatory training sessions have also been reviewed with new ideas being implemented.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted and discussion with the FSM and CNM.</p> <p>Residents and family/whānau members interviewed, along with the 2014 satisfaction survey results, identified that residents' needs are met by the service.</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>The policy identifies that at all times, adequate numbers of suitably qualified staff are on duty to provide safe care to residents. There are always three RNs on day shift and three on the afternoon shift. There are six staff on the night shift (two RNs, one enrolled nurse (EN) and three HCAs). Each area has an allocated number of HCAs. Enrolled nurses are employed and work across each of the three shifts. An example of a roster over a week period was reviewed and discussed with the CNM. This showed that contractual requirements and safe staffing levels are documented. There is a pool of RN, EN and HCAs available to fill in roster gaps as and when required. Examples of extra staff being provided were discussed. Several changes have been made to staffing in the past year, following a review and consultation process with staff in December 2014. This has included an extra HCA role over busy periods and a supporting RN role to assist with medications, accompany the GP, review care plans, support HCAs and for various other support tasks.</p> <p>Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Residents and families interviewed stated all their needs, or their family member's needs have been met in a timely manner.</p> <p>Nursing and care staff are supported by a multidisciplinary team, including physiotherapists, diversional therapy staff, GPs and specialist staff. Cleaning staff, although a contracted service, are based at the Talbot Park site. Laundry services are provided by a contracted service</p>

		at the Timaru Hospital site.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>There was no personal or private resident information on public display during the audit. The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all residents' information sighted. Clinical notes are current and integrated with GP and auxiliary staff notes. The files are kept secure in each wing and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, national health index number (NHI), the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers are all recorded in each resident's record.</p> <p>Archived records are held off site in the SCDHB secure medical records department. These are catalogued for easy retrieval.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>When the need for service by Talbot Park had been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner.</p> <p>Information about the service includes full details of the services provided, its location and hours, how the service is accessed and identifies the process if a resident requires a change in the care provided.</p> <p>Files reviewed contained completed assessments. Signed admission agreements met contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented</p>

		in the progress notes.
<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>	FA	<p>The Medication Management Policy is comprehensive and identifies all aspects of medicine management.</p> <p>A safe system for medicine management is observed on the day of audit. The RN observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All RN's who administer medicines are competent to perform the function they manage.</p> <p>Controlled drugs are stored in a separate locked cupboard. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidences weekly and six monthly stock checks and accurate records.</p> <p>The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.</p> <p>The GP's signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP review was sighted.</p> <p>There are no residents who self-administer their medicines.</p> <p>Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are used and documentation is compliant with guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided from the main kitchen at the Timaru Hospital site. This is a contracted service. Dietitians have developed the menus and are available to support individual residents with specific needs. A dietitian visits two weekly and examples of special diets being developed to meet individuals' needs were sighted and discussed with the CNM. Residents are routinely weighed at least</p>

		<p>monthly and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. There have been issues in the past related to food temperatures being lower than required when served to residents at Talbot Park. Improvements have been made to insulation of food during transport from the hospital and increased awareness by staff around prompt delivery of meals. Temperatures are monitored each day and demonstrate an improvement and that the required temperatures have been met on most occasions over the past week. The CNM is continuing to monitor this closely. Satisfaction with the food service varied between those interviewed, with some stating the food is nutritious, plentiful and meets their (or their relative's needs) and others reporting the food is 'dull'. Food is available 24 hours a day in the dementia care area.</p> <p>The kitchen at the Timaru Hospital was not visited as part of this audit. Documentation sighted provided evidence that there is a current Food Safety Inspection Certificate for the kitchen, issued on 13 October 2014. All aspects of food storage onsite in the Talbot Park kitchen areas reviewed showed that food was stored as required. The kitchen area in the Hunter wing needs maintenance; this is raised in Standard 1.4.2.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>An interview with the CNM verified a process existed for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry would be communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services.</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>On admission, residents have their needs identified through a variety of information sources that includes the Needs Assessment and Service Coordination (NASC) agency, other service providers involved with the resident, the resident, family/whanau and assessments using a range of assessment tools. The information gathered is documented and</p>

		<p>informs the initial care planning process. This takes place in the privacy of the resident's bedroom or the whanau room with the resident and/or family/whanau present if requested.</p> <p>Over the next three weeks, the RN undertakes an interRAI assessment. This, in addition to assessments from the diversional therapist, dietician, physiotherapist and allied health providers identifies each resident's needs, outcomes and goals. Assessments are reviewed six monthly or as the needs of the resident changes. A medical assessment is undertaken within 24 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable. A multidisciplinary review is undertaken monthly.</p> <p>Four RNs are trained in using the interRAI assessment tool and another RN is in the process of training with another waiting to start. All new residents are assessed on admission using the tool, with other residents being assessed as assessments due or condition dictates.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Assessment data in consultation with the resident and/or family/whanau informs the care plan and describes the required support the resident needs to meet their goals and desired outcomes.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to those concerned.</p> <p>Care plans are evaluated six monthly or more frequently as the resident's condition dictates. Interviews and documentation verified resident and family/whanau involvement.</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>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes.</p> <p>Residents and family/whanau members expressed satisfaction with the</p>

		<p>care provided.</p> <p>There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents' needs.</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>	FA	<p>Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities programmes operate in both areas of the facility seven days a week and in the specialist unit till 7.30 pm. Activities are managed by a trained diversional therapist, with assistance from six activities assistants. Activities reflect residents' goals, ordinary patterns of life and include normal community activities and separate activities for younger residents. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.</p> <p>A residents' meeting is held three monthly. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback and satisfaction with the activities provided is sought.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated daily and reported in the progress notes. If any change is noted it is reported to the RN.</p> <p>Formal care plan evaluations measuring the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans are reviewed daily, weekly or</p>

		fortnightly as indicated by the degree of risk noted during the assessment process. Interviews verified that residents and family/whanau are included and informed of all changes.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non urgent services is indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the SCDHB. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident to the emergency department in an ambulance if the circumstances dictate.</p> <p>Psycho-geriatric specialists attend the specialist unit every two weeks, though respond promptly outside those timeframes when input is required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>The waste management policy includes detail on the safe disposal of all types of waste. This includes segregation (hazardous, controlled and non-hazardous), packaging, labelling and storage of healthcare waste. Waste management strategies for all staff are included at induction and orientation. Staff interviewed demonstrated knowledge and understanding of safety issues around managing waste and hazardous substances. The localised hazard register reviewed was current, well completed and had been updated. Chemicals were stored securely and one of the contracted cleaning staff interviewed who has worked at Talbot Park discussed management of the few cleaning products, management of any hazards and identified material safety data sheets.</p> <p>Sluice rooms are conveniently located to service areas and are functional. Personal protective equipment (PPE) was available, although full face masks were purchased, in addition to the eye protection already available, on the first day of the audit. Staff were seen to be using PPE during the two days of the audit.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building, despite being older, is generally being well maintained, with refurbishment improvements made in several areas since the last audit. The newer area of the dementia care unit is spacious and fit for purpose with a good flow for those who are mobile. The current building warrant of fitness expires on 1 December 2015. One of the kitchen areas is in need of refurbishment.</p> <p>There is a full time maintenance person on site and staff interviewed and documentation reviewed demonstrate a responsive maintenance process. The functional testing of beds has not occurred and this is not on the list of equipment sighted for functional testing. There is no list available of all electrical equipment that requires testing, although all equipment reviewed on site had evidence of testing and tagging within the past year. Fire safety equipment and hoists are regularly checked for safety, although one fire hose in the dementia area was not tagged. All other fire hoses were tagged and the maintenance person believes that the tag had been removed. An appointment with the testing person was made during the audit to address this.</p> <p>One of the bathroom areas in one of the hospital wings has two showers with curtaining between these areas. Although staff are mindful of privacy issues this environment does not support auditory privacy.</p> <p>Residents were observed to be moving around the facility independently with ease, some using walking aids. The facility is divided into three areas (two hospital areas) and one secure dementia care area. Carpets are in good condition and handrails are available. External areas are safe for residents in both areas with improvements recently made to develop a 'pedestrian walk way' near the car park area, as a result of suggestions by family members. One of the external areas attached to the dementia care area, has a gentle slope and this is locked during the winter days when there is any risk of slipping following a frost.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	<p>FA</p>	<p>Sufficient numbers of toilets and bathroom areas are available in all</p>

<p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>three areas of the facility. These have occupied and not-occupied signage. The signage in one bathroom in the dementia area was missing on the first day of the audit and this was addressed immediately. There is one shared bathroom which does not meet privacy requirements (Refer 1.4.2). Hot water temperature monitoring is occurring on a random basis monthly with every tap checked at least three monthly. Temperatures meet requirements and where this is not the case the FSM reports that this is addressed. One example reviewed showed a slightly increased temperature and there was no evidence of action taken. This was rechecked on the day of audit and was within the required range.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is a mix of single and double rooms. The double rooms are large and have curtains for privacy. One family member interviewed whose mother shares a room, reports that this works well for her relative and privacy is assured by staff. Rooms are of varying size and meet the requirements of residents and staff. Each is personalised to the resident's liking with comfortable furniture. Relatives interviewed spoke of improvements made to chairs to support ease of getting in and out of them. There is enough room for the resident to move around safely with or without a mobility aid. Residents and families interviewed were happy with the facilities.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>A number of lounge and dining rooms are available with extra family spaces created in the past year. Activities occur in various locations within the facility and there are a number of options for residents and families to access. This was observed during the audit. Facilities in the secure dementia area meet the requirements of residents with special needs and are comfortable and spacious with a good flow. During the audit residents in this area were noted to be well occupied and staff were able to observe behaviour easily without being intrusive. Residents and family members interviewed were happy with the spaces provided.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is carried out off site at the Timaru Hospital laundry. This was not visited as part of this audit. The 2014 satisfaction survey indicated some issues related to laundering of personal items and since then a dedicated person in the laundry oversees Talbot Park laundry. Although there were some examples noted of ongoing issues (eg, slow return and missing items) both staff and relatives interviewed reported improvements in this area.</p> <p>Cleaning at Talbot Park is a contracted service with staff employed who have worked at the site for many years. The FSM, staff and relatives reported satisfaction with the service and the facilities were noted to be clean during the two days of the audit. The organisation conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective. Areas for safe storage of chemicals and cleaning equipment were noted and reviewed with one of the cleaning staff. This person discussed the cleaning routine, staffing arrangements, training provided in relation to infection control and chemicals used, and the daily cleaning of mop heads.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Talbot Hospital is part of the SCDHB emergency plan, which was discussed with the emergency manager from the DHB. Arrangements in a range of emergencies were discussed and this included access to sufficient food and water for five days for the Talbot Park site. An example of the plan being implemented during a severe snow storm in 2006 included coordination of health services across the region. Talbot Park is also a part of the South Canterbury Residential Care Providers emergency communication cascade.</p> <p>An approved fire evacuation scheme (March 1996) was sighted. This remains current. Fire drills are occurring every six months and staff interviewed knew what to do in an evacuation emergency. Staff receive information on emergency procedures at orientation and there is ongoing training about civil defence processes and keeping residents safe during emergencies. An 'emergency box' was sighted with a range of appropriate equipment (eg, cell phone) and 'flip charts' covering a range of emergencies are well displayed around the facility. An example of a telephone 'outage' the week prior to the audit resulted in</p>

		<p>a learning opportunity for all those on site and was managed adequately. An emergency generator is on site and regularly tested. There is always a registered nurse on site and sufficient staff who have had life support and emergency training.</p> <p>Call bells are available in all areas, and although these are not formally monitored for timely response, no issues have been identified to indicate that staff do not respond when summoned.</p> <p>The facility has auto-sensing lighting and the facility is monitored by a security company during the night. Staff lock and check the building on the afternoon shift. The dementia area is a secure area with key pad access. A recent incident (refer Standard 1.2.4) of a resident leaving the secure area and the facility was reviewed and discussed with the FSM. A root cause analysis is in progress in relation to this. Security cameras are now in the area and staff and families of residents have been reminded of the importance of ensuring the door is properly secured after they exit. Adjustments to the door have also been made to improve the closing mechanism.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The facility was warm and dry on the days of the audit, with wall mounted heating throughout. There were no concerns expressed in relation to heating and ventilation. Adequate natural lighting is in all bedrooms and common areas. Residents and families expressed satisfaction with the facilities.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme.</p> <p>The infection control programme, reviewed annually, establishes, maintains and monitors procedures covering infection control practices.</p> <p>The infection control practices are guided by the infection control manual, with assistance from an external infection control advisor and the DHB infection control nurse where needed.</p> <p>It is the responsibility of all staff to adhere to the procedures and</p>

		guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these policies was sighted at audit. Reporting lines are clearly defined.
<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 infection control and prevention nurse (ICPN) is responsible for implementing the infection control programme with assistance from the ICPN from SCDHB. A position description is included in the infection control (IC) programme. The infection control committee meets three monthly and reviews policies, procedures and surveillance data, implementing changes if required.</p> <p>The ICPN and observation verified there are enough human, physical and information resources to implement the infection control programme. Training records sighted and interview verified the ICPN attends IC training.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control programme includes policies and procedures that are practical, safe and appropriate for the type of service. Policies are current and signed off by ICPN.</p> <p>Staff interviewed verify knowledge of infection control policies. Staff were observed to be compliant with general infection control practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verify staff have received education in infection control and prevention at orientation and ongoing education sessions. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectation.</p> <p>Resident education occurs in a manner that recognises and meets the residents' and the families' communication style, as verified by resident and family interviews.</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>	<p>FA</p>	<p>In line with the infection prevention and control policy and procedures, monthly surveillance is occurring. These are collated each month and analysed to identify any significant trends or possible causative factors. Incidents of infections are presented at the quality meeting and staff meetings every month. Any immediate action required is presented to staff at hand over. Any ongoing actions required are presented to staff at staff meetings and any necessary corrective actions discussed, as evidenced by meeting records, infection control records and staff interviews. Incidents of infections are compared to previous surveillance records. A comparison is used to analyse the effectiveness of the programme.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint minimisation policy reviewed meets the requirements of the Standard. The only restraints used at Talbot Park are lap belts with leg straps. The only approved enablers are lap belts and bedrails. The policy details the process for assessment, approval, evaluation and monitoring. The specialist dementia care unit is a secure environment.</p> <p>On the days of audit the restraint register listed one resident using a restraint and two residents using enablers; one of whom had been very recently discharged. Restraints and enablers are approved using the same process. The one enabler in use was a lap belt to support a resident to remain safe and support privacy and dignity while toileting. This was initially being treated as a restraint but now was considered a voluntary enabler. A relative of this resident interviewed had been involved in this process and when interviewed discussed the benefits to the resident. From time to time a respite care resident requires restraint for safety reasons and an example of this was also noted in the register reviewed.</p> <p>A range of equipment and processes are used to ensure the least restrictive option and staff interviewed were aware of the difference between a restraint and an enabler and the voluntary nature of an enabler.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	<p>FA</p>	<p>The FSM is the restraint coordinator and the CQI Committee acts as the restraint approval group. The FSM and staff interviewed are clear about the approval process and requirements for restraint. The minutes of this committee were reviewed and discussed with the FSM and showed an example of approval for use of lap belts and a lap belt with leg straps. The one resident who is using a lap belt with straps is in the dementia area and doing so to prevent falls.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A rigorous process was reviewed for the one resident in the dementia unit using a restraint. This was first approved for use in November of 2013 and has been used on and off since then with reducing regularity and for reducing lengths of time. An updated approval process occurred in June of 2015 by the CQI Committee. All restraints in use are reviewed yearly. This same process was used for the one person using an enabler (initialling treated as a restraint). The initial approval was discussed with a relative of the resident who has been involved in the regular six monthly reviews of this, and signed in the record accordingly. All requirements of the standard were covered as part of the assessment process.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The one example of the restraint in use demonstrates that this is used to maintain safety and is the least restrictive option for this resident. The relative of the person has been involved in the process and this is included as part of the long term care plan and commentary is included in the progress notes. All staff have training in non-violent crisis intervention and those interviewed feel competent to manage the approved restraint. All staff involved with restraint are required to have had one year of experience in aged care; this is stated in the protocol.</p> <p>Observation and monitoring requirements are defined and records of this show decreasing periods of use and no use over the two months prior to the audit and one short period of use in April 2015. Each episode of restraint has all the necessary details fully completed. The FSM reports the decrease in use is due to increasing staff awareness of the resident's needs and other environmental changes in the</p>

		dementia area. The restraint record review meets all the requirements of the Standard.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Each episode for the one restraint in use has been fully evaluated and shows appropriate use, monitoring, evaluation and decreasing use since December 2014. When any restraint (or enabler), is first used an evaluation occurs after the first two weeks and thereafter monthly and then, in the case of the resident in the dementia area, six monthly. Related documentation demonstrates that all requirements have been met.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Quarterly and yearly reporting to the CQI Committee on restraint use occurs, as discussed with the FSM and signed in the Committee minutes. Episodes of restraint, including those associated with one resident regularly receiving respite care, have reduced from 70 in the first quarter of June 2014 to 19 in the fourth quarter (June 2015). Audits have been completed on the restraint process and show minimal and minor issues only. Changes to the DHB education programme, attended by Talbot Park staff, are being considered to improve the relevance to the aged care setting (refer also 1.2.7).

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 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	<p>There is a list/inventory of equipment requiring functional testing and this has been completed as required. Beds are not included in this list, and although tested for electrical safety, functional testing has not occurred.</p> <p>Electrical testing and calibration of equipment occurs as part of the DHB testing programme on a yearly basis. There is no central list maintained of all equipment requiring this type of testing, to ensure all pieces of equipment are included. There were no items checked on site that required testing, that had not been tested and tagged.</p> <p>In the kitchen area of the Hunter wing there is paint peeling off the wall, the floor carpet area is stained and the area needs upgrading to meet current food</p>	<p>The electric beds used throughout the facility have not been tested for functionality. There was not a list available of all electrical equipment that needs to be tested for electrical safety. The kitchen area in the Hunter wing requires maintenance. The current shared bathroom does not meet privacy requirements.</p>	<p>There is a complete list of all equipment that requires both electrical and functional testing and that testing is completed as required. Maintenance is completed in the Hunter wing kitchen area to ensure food safety and hygiene standards are met. Bathroom facilities are reviewed to ensure that auditory privacy is maintained.</p> <p>180 days</p>

		<p>safety and hygiene standards.</p> <p>There are shared bathroom facilities (ie, two showers in the same shower room) and although these are not often used for two people at the same time and there are curtains to pull across, this does not ensure verbal privacy for residents, as required in the Code of Rights.</p> <p>Residents and families interviewed were happy with the facilities.</p>		
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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.