

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: 31 May 2017 End date: 31 May 2017
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:	23

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

General overview of the audit

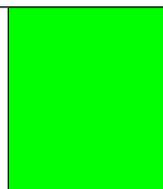
Talbot Park provides specialist hospital level psychogeriatric care for up to twenty-five residents in Timaru. The service is operated by South Canterbury District Health Board (DHB) and managed by an on-site charge nurse manager and the off-site manager of mental health and addictions. Since the previous audit, the service has transitioned out of the provision of hospital level care and closed a section of the facility. All residents who require a secure environment are located in Watlington wing.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract for Aged Residential Hospital Specialised Services Agreement (ARHSS) with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, contractors and a general practitioner.

This audit has resulted in a continuous improvement in managing resident transfers and identified areas of improvements relating to diversional therapy planning and evaluation and the timeframes for completion of initial assessments. Improvements have been made to functional and electrical testing completion, addressing the one area requiring improvement at the previous audit.

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.

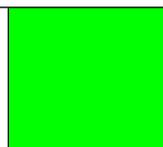


Standards applicable to this service fully attained.

A complaints register is maintained with a small number of complaints resolved promptly and effectively. Open communication between staff, residents and families occurs, with open disclosure adequately documented.

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.

A current quality improvement plan includes the annual quality objectives for the 2016 – 2017 year. Results of monitoring of the service is provided to the district health board through the management structure each month. An experienced and suitably qualified person manages the day to day operation of the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved in improvement activities and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are developed by the DHB or Talbot Park. Those sighted were current and regularly reviewed.

There are established processes for the appointment, orientation and management of staff based on current good practice. A systematic approach to identify and deliver ongoing training for all staff groups supports safe service delivery, and includes regular

individual performance review. Staffing levels and skill mix has recently been reviewed with new rosters introduced to reflect the changes to resident numbers.

Continuum of service delivery

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

Information is accessed from a wide range of multidisciplinary sources to contribute to initial care planning when a resident first enters the facility. Residents' care plans are individualised and easy to follow. Caregivers use the information to guide the services they deliver. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Updates are made to care plans when indicated and residents are referred to other specialist health services as required.

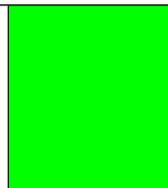
The planned activity programme provides residents with a variety of individual and group activities over seven days of the week. Twenty-four hour individualised diversional therapy plans are in residents' files.

Medicines are safely managed according to organisational policies and procedures and relevant legislation and guidelines. The medicine system is overseen by registered nurses and the administration of medicines is undertaken by staff who are competent to do so.

Food is provided by the local Timaru Hospital and meets the nutritional needs of the residents. Special needs and personal preferences are catered for, including in the provision of cutlery and crockery. Residents are provided with choices and snacks are available over 24 hours.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

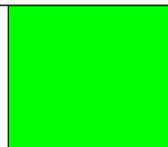


Standards applicable to this service fully attained.

There is a current building warrant of fitness. There have been no changes to the building since the previous audit. Electrical and functional testing of equipment is undertaken.

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.

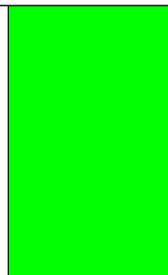


Standards applicable to this service fully attained.

Talbot Park is a secure environment. One resident uses restraint for short periods during the day and there are no enablers in use.

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 clinical nurse manager is also the infection control coordinator and leads the management of the infection prevention and control surveillance programme. Infection surveillance undertaken is specific for aged care, although is managed through a local district health board electronic incident reporting process. Data from the programme is used to inform quality improvement decisions around the prevention of spread and recurrence of infections. Follow-up action is taken as and when required.

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	14	0	2	0	0	0
Criteria	1	35	0	2	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>An up to date complaints register is maintained. It showed that one complaint received over the past year has had formal action taken within the timeframes required by the Code of Health and Disability Services Consumers' Rights, through to an agreed resolution. The action plan shows any required follow up and improvements have been implemented. The service manager is responsible for complaints management and follow up. She reports that any concerns are addressed at an early stage which limits the use of the formal complaints processes. Complaints forms are readily accessible at reception.</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>Family members stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records and incident reports reviewed. Staff understood the principles of open disclosure, which is supported by the organisation's policies and procedures.</p> <p>Staff know how to access interpreter services via the DHB, although this has not been required since the previous audit.</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 strategic direction for the organisation includes the intention to exit all services provided in the facility. This process is continuing, with closure of the hospital care component of the service occurring on May 18th 2017 after transfer of the few remaining residents to other facilities. This strategy has involved two rounds of redundancy for the existing staff. The remaining psychogeriatric service of twenty-five beds is expected to transfer to a private provider in the next two years, resulting in full closure of the facility at that point. The goal has been to support residents and families through the closure process. There has been extensive consultation with staff, families and the wider community, however there is acknowledgement that it has been a stressful and uncertain time for all involved. Staff have been offered access to confidential employee assistance.</p> <p>The new arrangements have also involved a restructure of the remaining service. It now comes under the oversight of the manager of mental health and addictions at the DHB, with the day to day operation undertaken by an experienced charge nurse manager on the Talbot Park site. She holds relevant qualifications in nursing and has undertaken post graduate papers in nursing, delirium and dementia, leadership and management and has recently completed the “Leading the walk” workshop which can link/compliment the “Spark of Life” programme she has previously completed.</p> <p>A structured reporting programme ensures key performance indicators are reported to the DHB each month. Adequate information to monitor performance is provided. Back of house functions provided by the DHB include financial services and human resources management. The service continues to utilise the DHB contracted providers for food and household services.</p> <p>The service holds contracts with the DHB for aged residential care services. Twenty-three residents were receiving services under the contract at the time of audit.</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 planned quality and risk system linked to the SCDHB framework that reflects the principles of continuous quality improvement which is documented in the Quality and Risk Plan 2016-2017. This includes management of adverse events, near misses and complaints using an electronic reporting system, internal audit activities, an annual satisfaction survey, clinical incidents including infections and restraint use.</p>

	<p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators using a set agenda and that related information is reported and discussed at the registered/enrolled nurse meeting, continuous quality improvement (CQI) (which includes relative representative), and senior leadership group. Other forums to review quality indicators and projects include staff team meetings (MDT meetings, RN and EN meetings). Staff reported their involvement in quality and risk management activities through internal audit activities, health and safety representation and involvement in projects, such as the continence improvements. Relevant corrective actions are developed and implemented to address any shortfalls in services. A recent example of follow up from a complaint in relation to the food service was addressed and monitored until the changed processes were embedded into practice. Family members interviewed confirmed any concerns they have are addressed and they are satisfied with services delivered and improvements made.</p> <p>Family satisfaction surveys have been completed annually, however some review of this will be necessary to reflect the changed resident demographic. The most recent survey focused on personal care, meals, social activities and other individualised care factors. Results showed the least satisfaction related to the activities programme (60% satisfaction) and access to nutritional advice (50%), while highest satisfaction related to the environment and personal care. It is reported that involvement of family members on the CQI group has been helpful in addressing any issues which arise.</p> <p>Generic policies are developed by the DHB and supported by Talbot Park specific procedures. These are reviewed on a regular cycle and cover all necessary aspects of the service and contractual requirements, are based on best practice, and those reviewed were current.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Examples of specific risks in relation to the closure of the hospital wings and associated security and fire risks have been considered and mitigated. There is a process to ensure new risks are reported through to the board to be included on the organisation wide risk register. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The SCDHB Health and Safety Committee is active and the hazard register is regularly reviewed. The organisation is included in the ACC Workplace Safety Management Programme.</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>Staff document adverse and near miss events using the DHB electronic system “Safety First”. A sample of incidents reports reviewed showed these were fully completed, investigated where necessary, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed for trends (eg., falls and infections) and reported through the committee structure.</p> <p>The facility manager understands essential notification reporting requirements, including for pressure injuries. She advised that no notifications of significant events have been made to the Ministry of Health since the previous audit. A notification in relation to the change of manager is underway.</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>Human resources management policies and processes are developed by the DHB and based on good employment practice and relevant legislation. The recruitment process includes advertising, shortlisting of applicants, referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained. No new external staff have been employed in the last year, as the organisation’s restructure and downsizing is implemented.</p> <p>Staff orientation includes all necessary components relevant to the role. This includes a generic DHB format as well as a Talbot Park specific component. Staff records reviewed show documentation of an annual performance review. The system for annual practising certificates (APC) for registered and enrolled nurses is implemented and records maintained.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements such as fire, cardiopulmonary resuscitation (Level 2 and 3). The programme reviewed offers a wide range of relevant mandatory and topics of interest offered internally or by the DHB. A recent initiative has seen some sharing of education with the mental health service, with some of the sessions to be held on the Talbot Park site. There is a system to records any internal training undertaken. There are opportunities for staff to apply for support to attend external courses relevant to their role.</p> <p>Health Care Assistants (HCA) have completed certificates in Health and Wellness level three, with some also completing level four on the New Zealand Qualification Authority framework to meet the requirements of the provider’s agreement with the DHB. Staff have also participated in the DHB offered programme “Walking in Another’s Shoes”. Staff working in the dementia care area have either completed</p>

		<p>or are enrolled in the required education – this includes fully trained diversional therapists. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. The intention is to have all six registered nurses interRAI trained. Records reviewed demonstrated completion of the required training, competencies and completion of annual performance appraisals for all staff. Only the charge nurse manager is engaged with the professional recognition and recognition programme (PDRP).</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>	FA	<p>With the downsizing of the service, there has been a corresponding review of staffing levels for the remaining specialist psychogeriatric service. At the time of audit, it is the second week of the new roster. The staffing levels and skill mix ensure there is a minimum of three staff on every shift, with a skill mix of registered, enrolled nurses and health care assistants. Registered nurses are rostered 24 hours a day, seven days a week (24/7). Enrolled nurses currently work five hour shifts. The diversional therapist and diversional therapy assistants complete an eight-hour shift finishing at 7.30pm on their seven-day roster. Care staff reported there were adequate staff available to complete the work allocated to them, however there is now less flexibility with the reduced staff numbers and overall hours.</p> <p>The facility will be refining staffing levels over the next few weeks and adjusting staffing levels to meet the changing needs of residents. Observations and review of the initial two-week roster confirmed adequate staff cover has been provided, with fluctuating staff numbers to cover the busy periods. Staff state they are still adjusting to the roster changes and the manager reports this is still being fine-tuned. An example of a roster amendment has already occurred.</p> <p>Registered nurses will fill any short notice roster gaps from within the staffing complement, however there is back up support from the duty managers based at Timaru Hospital. Families interviewed are satisfied with the staffing levels. Clinical staff are trained in cardiopulmonary resuscitation level three. All registered nurses and enrolled nurses are trained to level three and are current, while HCA's are trained to level 2. There is 24 hour/seven days a week (24//7) RN coverage in the unit.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with legislation and the Medicines Care Guide for Residential Aged Care.</p>

<p>requirements and safe practice guidelines.</p>		<p>Medicines are being stored safely in a locked medicine room that has a numeric key pad for entry. Records sighted confirmed medicine fridge temperatures are being checked daily. Registered nurses are responsible for medicine management and all have a current medicine competency as well as a syringe driver competency. There are a number of caregivers who have controlled drug checking competencies to assist the registered nurse on evening and night shift.</p> <p>Although the GP expressed a preference to have an electronic medicine management system, this is not yet available. All medicine records that were reviewed met requirements with allergies documented, all prescriptions signed and dated and all discontinuations of medicines dated and signed by a doctor. The reasons for using a prn (pro re nata) medicine are documented, GP reviews of medicines are evident on the medicine records and verbal orders are being signed off. Standing orders are current and signed by GPs, a document for guiding when a medicine may be crushed is available, staff are familiar with the requirements of the process for managing verbal orders of medicines and the controlled medicines are being managed safely. Random checks showed accuracy and that ongoing monitoring is occurring as required.</p> <p>Talbot Park uses the pharmacists from Timaru Hospital who pre-package the residents' medicines and there was evidence of their involvement. All unused medicines go back to Timaru Hospital.</p> <p>As Talbot Park is a psychogeriatric service there are no residents who self-administer medications, therefore this criterion has been marked as not applicable.</p> <p>Medicine administration records, including the signing of each medicine following administration, meet requirements. Observation of the lunchtime medicine administration round demonstrated good practices are being upheld. There is an implemented incident reporting process for comprehensive analysis of any medication errors.</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>	<p>FA</p>	<p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. All meals are supplied by Timaru Hospital according to a three week cycle with winter and summer variations; with toast being made for breakfast at Talbot Park. The menu was last reviewed by the dietetic service in March 2017. The menu is on the noticeboard and each day the charge nurse manger completes individual menu record sheets. These sheets are named with one for each resident. They are also colour coded according to the</p>

		<p>type of food the person needs and prefers. For example, the pink sheets are for a soft diet, green for diabetic, purple for puree, yellow for mince moist and white for standard. All meal record sheets state the size of the meal and any additional requirements, such as any specific cutlery and crockery needs.</p> <p>Residents' service delivery plans described the level of assistance each person requires, or if any additional food supplements are issued for any resident. There were two examples within the sample of residents' files that were reviewed, of a dietitian having been involved in assessing their nutritional needs. Records show that the nutritional needs of seven residents are monitored by a dietitian with updated reports of reviews on file.</p> <p>Sandwiches, cookies, fruit and snack foods are examples of food supplied by the kitchen to ensure residents have access to something to eat over 24 hour timeframes. Staff reported that at times they may take an unsettled resident to one of the side lounges and provide them with a cup of tea and something to eat.</p> <p>Prepared food is transported to Talbot Park on individual trays in a covered heated trolley from Timaru Hospital. Hence, it was not possible to ascertain whether all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. However, the food management processes undertaken at Talbot Park meet requirements. Records were sighted to confirm that fridge temperatures are being checked daily and the temperature of food is checked prior to leaving Timaru Hospital and on arrival at Talbot Park but prior to distribution. There have been some issues with the food not being of an optimum temperature on arrival at Talbot Park and staff informed they use the microwave to heat the food to a more acceptable level when necessary. The charge nurse manager described the ongoing monitoring and ensuing conversations and changes made to food service systems to ensure that food is kept at a safe temperature and that it is acceptably hot prior to serving.</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 with family members and staff verified the provision of care provided to residents is consistent with their needs, goals and the plan of care. Care plans and service delivery are individualised and observations and conversations throughout the audit showed that staff are extremely familiar with each person and their needs. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent despite the ageing facility. Caregivers confirmed that care was provided as outlined in the documented service delivery plans and as per</p>

		handovers and instructions from registered nurses. Residents appeared comfortable and were well presented. Ongoing efforts to occupy the residents were being made and they were assisted at the times that suited the individual person best. A number of successful gentle techniques to distract or redirect residents were observed throughout the audit.
<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>	PA Low	<p>On the day of audit, there were two qualified diversional therapists with the national Certificate in Diversional Therapy. They cover eight and seven shifts respectively per fortnight. Shifts are all eight hours. Due to a recent resignation, the number of activity staff will soon reduce to one diversional therapist covering seven shifts a fortnight until a replacement is found.</p> <p>The diversional therapists develop a monthly activity programme and examples sighted showed a diverse range of activities are made available to residents. Topics reflect season and festivals as well as cover walks, music, stories, exercises, outings and visits from community members and groups. Activities for residents in this secure dementia unit are specific to the needs and abilities of the people living there. One on one activities are undertaken and built into the schedule. Staff, including caregivers, were observed encouraging residents, to move around, go outside, cuddle a toy animal or doll (as applicable for the person) or use the fiddle boards as they moved around. Family members informed that overall residents are well occupied and noted there is a wide range of ways families/visitors can be involved.</p> <p>A comprehensive social assessment and history is undertaken when a resident is admitted to ascertain their needs, interests, abilities and social requirements. A 24 hour diversional therapy plan is then developed on a template that requires eight different goals and sets of interventions. Participation in various activities are recorded in an individualised tick sheet. Improvements are required related to activity reports and evaluations as these were not current nor reflected personal goals.</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 on each shift and reported in the progress notes. If any change is noted, it is reported to a registered nurse who is responsible for taking appropriate action.</p> <p>A multidisciplinary team meeting is undertaken every month and a brief summary of the discussion about each resident is documented all of the resident's files that were reviewed.</p>

		<p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment and as resident's needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care and examples if updates were evident in all resident files sighted. There was a gap in the evaluations and reviews of diversional therapy plans and this has been noted in section standard 1.3.7 (Planned Activities) in this report.</p> <p>Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, skin tears and wounds. When necessary, and for unresolved problems, long term care plans are added to and/or updated. Family members stated they believe their feedback is valued by staff and contributes to how their relative is cared for.</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>	FA	<p>A current building warrant of fitness was issued on 21 December 2016. No structural changes have been made to the building since the previous audit. The shutdown of two previously occupied wings has included discussion and site review by the New Zealand Fire Service. Changes to the approved Fire evacuation scheme has not been required.</p> <p>A previous corrective action in relation to electrical and functional testing has been addressed. Inspection on the day of audit indicates a system is in place, with an externally contracted provider completing the servicing requirements. Equipment checked indicates several items of equipment are due for checks in May 2017. The provider is scheduled to be in the area 14 – 16 June 2017 to complete testing for the items on the schedule.</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 process for surveillance of infection is described within the organisation's policies and procedures. Details of any incidence of a suspected infection are entered into the risk based 'Safety First' electronic system, which is a district health board computer programme. The data related to Talbot Park is able to be extracted from the wider district health board services. Each infection is managed independently of one another for the purposes of treatment and review of the actions taken. The charge nurse manager, who is also the infection control coordinator, reviews the infection incidents at least monthly to ascertain the number, type, possible causes, severity and any recurrence. A summary report and related graphs are produced and the infection data is analysed in consultation with registered nurses and enrolled nurses at their meetings. Minutes of Talbot Park quality and risk meetings demonstrated that infection reports are presented at these. Any quality improvement infection prevention opportunities are actioned</p>

		<p>and followed through. Talbot Park's infection surveillance programme is consistent with the expectations of an aged care facility.</p> <p>A verbal report about how a gastrointestinal infection outbreak that occurred in the previous hospital area was provided. The charge nurse manager reported the preventive actions taken, including the ongoing monitoring and staff education, as the most likely reasons why there was no spread of the infection beyond the hospital wing into the Psycho geriatric wing.</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 service is a secure facility, with residents assessed as requiring this level of care prior to entry.</p> <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. On the day of audit, no residents were using enablers. One resident has been assessed as requiring a restraint in the form of a lap belt and leg straps for short periods up to twice per day. All expected documentation including assessment, consent, monitoring and evaluation forms are completed. Internal audit results of these records were sighted. Ongoing reviews and reassessments were evident in the documentation. Restraint use is reported as a set agenda item at the registered and enrolled nurse meetings and via the charge nurse manager report to the DHB. This includes the total number of times/events that restraint is used per month. Recent reports indicate this is 40 – 50 times/events per month for this resident. There is support and oversight for enabler and restraint management, with staff demonstrating a sound understanding of the requirements.</p> <p>Data reviewed indicates that there has been a consistent decline in the use of restraint in the facility. A similar process is followed for the use of enablers as is used for restraints.</p>

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 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>An initial nursing assessment and a series of targeted assessments including for falls, sensor mat, mobility, pain, nutrition, skin integrity and behaviour are being completed within 24 hours of admission to the facility. New residents are being seen by a GP within 48 hours for a clinical review. Short term care plans are being used when appropriate and reviews undertaken in a timely manner.</p> <p>InterRAI assessments are being completed for residents' six monthly reviews. However, not all residents are having an interRAI completed within three weeks of admission and printouts in residents' files were not always the current versions. Only two admission interRAI assessments could be found in</p>	Initial interRAI assessments and long term care plans are not all being completed within the expected timeframes as detailed within the Aged Related Residential Care Agreement.	<p>Ensure that interRAI assessments and long term care plans are completed for all new residents within the timeframes as required in the Aged Related Residential Care Agreement.</p> <p>180 days</p>

		<p>the six residents' files that were fully reviewed. Archived records were checked, and an additional five residents' records (total 11) both in hard copy and in the electronic system, were reviewed specifically to ascertain the level at which interRAI is being redone on admission. There was evidence in the electronic system of interRAI assessments having been done for another four residents, but the records in the hard copy files were from assessments undertaken by NASC prior to admission.</p> <p>Three of the six files reviewed showed that long term care plans had not been completed within the initial three weeks with one dated more than three months following admission. A low risk rating has been attributed to this finding as there are so many other assessments and sources of information being accessed.</p>		
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>A checklist that shows the level of participation in different activities is in each resident's file and these are being updated daily. Evaluation notes on the rear of the tick sheets are written up most weeks; however, these are more of a nursing progress report about how the person is, or has been, rather than their involvement in activities. A change of diversional therapy plan documentation into a wellbeing plan has contributed to incomplete activity related information in residents' files. Each resident is required to have one goal under each of the headings on the template and it was evident that all eight were not always</p>	<p>Three of six residents' files that were reviewed did not have a current diversional therapy plan and the evaluations in diversional therapy plans do not reflect the level at which the resident have achieved their multiple goals.</p>	<p>Evaluation of the level of attainment of the goals in residents' diversional therapy plans are reviewed at least six monthly to ensure the activity plans and goals of residents are current and the activities being provided are meaningful to them.</p> <p>180 days</p>

		possible for each person. Three of six residents' diversional therapy reports were not up to date and the evaluations present were more of a summary and did not reflect the level of attainment of the person's documented activity goals.		
--	--	---	--	--

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<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>	CI	<p>Prior to commencing the hospital closing process, a plan was developed to manage risks associated with moving 24 remaining hospital residents from Talbot Park to six different facilities in the region. Associated risks were identified and the current suite of transfer documentation reviewed. The need to provide comprehensive details to the receiving facility to mitigate risk for the resident and achieve a smooth, safe transition was a priority. Existing documentation was reviewed, a cover check sheet developed and the ‘yellow envelope’ content enhanced to provide a holistic overview of the resident and their care needs. It also included a nursing transfer form, copies of EPOAs, Talbot Park resuscitation form, a large current photo, skin integrity report, medication orders and interRAI transfer completion. A review of the effectiveness of this initiative post discharge recorded any</p>	<p>An improvement initiative to provide current comprehensive information for 24 residents transferring from Talbot Park, enhanced the resident experience and reduced risks associated with their transfer. The new documentation has now been adopted as part of the standard transfer process.</p>

		<p>feedback received from the facilities involved. Comments related to the detail and thoroughness of the information provided. In particular, comments such as “the best transfer documents I have ever received”; “the current photo is very helpful”; and “thank you for such a thorough transfer envelope of papers – we could easily develop the initial care plan from the information you have provided”, were received. No issues with the documentation were encountered, however, two phone calls requesting further information were received from facilities which had not read all the documentation provided. Evaluation demonstrates the system has been effective and this format for transfer documentation will be retained for any transfers to other facilities in the future.</p>	
--	--	--	--

End of the report.