

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

Dates of audit: Start date: 18 July 2018 End date: 19 July 2018

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: 18

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 |
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|  | 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 |
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| 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 specialised dementia/psychogeriatric hospital level care for up to 25 residents in Timaru. The service is operated by the South Canterbury District Health Board and is managed by a charge nurse manager with support from a service manager. Significant improvements within this service were evident and this was confirmed during family and staff interviews.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with family members, management, staff and a general practitioner. Due to the nature of the service, resident interviews were limited.

This audit has resulted in two continuous improvement ratings. One is in relation to good practices around resident focused care and support, while the other relates to the manner in which continuous quality improvement is embedded into the organisation's quality and risk management system. Three areas requiring improvement were identified. These include the need for review of the winter menu, food temperatures at the point of serving which need to be warmer, and the contents and management of the emergency kit which need review.

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.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents, their families and their Enduring Power of Attorneys (EPOAs). Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents, their families and their EPOAs is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained with complaints resolved promptly and effectively.

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 sits within the wider South Canterbury District Health Board strategic plan, which includes short and long-term goals and action plans. These relate to the vision, goals, values and mission statement of the wider organisation. Reports on monitoring processes within Talbot Park are provided to the governing body every month and confirm effective services are being provided. An experienced and suitably qualified person manages the facility. Additional support is provided by a district health board service manager.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from families. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures pertaining to the service support service delivery, were current and are reviewed regularly. Adverse events are documented with corrective actions implemented and followed through.

The appointment, orientation and management of staff is based on current good recruitment and employment practices. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes annual individual performance reviews. Staffing levels and skill mix meet the changing needs of residents and levels of occupancy.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained using integrated hard copy files.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and expected outcomes are identified and reviewed on a regular basis. Families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by registered nurses, all of whom have been assessed as competent to do so.

The food service is provided off site by an external contracted service. Residents/family members verified overall satisfaction with meals.

Safe and appropriate environment

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| <p>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.</p> | | <p>Some standards applicable to this service partially attained and of low risk.</p> |
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required and bio-medical and mechanical equipment checks are being maintained. Communal and individual spaces are maintained at a comfortable temperature and repairs are completed as required. Internal areas have key pads in place to keep residents safe. Secure outdoor courtyards are accessible, safe and provide seating.

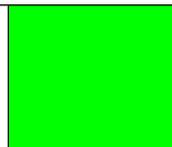
Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely handled according to training provided. Laundry is mostly undertaken offsite by a contractor as are cleaning duties. Audits to monitor the effectiveness of laundry and cleaning processes are completed both internally by the service provider as well as externally by the contractor.

Staff are trained in emergency procedures and the use of emergency equipment and supplies. Fire evacuation procedures are practised six monthly and fire safety equipment is consistently checked. A call bell system has been installed. Security is maintained according to documented processes and with assistance from a contractor.

All residents' bedrooms and communal rooms were warm and dry and have windows and doors that enable natural light to filter in.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

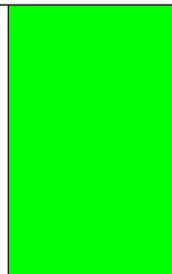


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. Other than environmental restraint being in place to ensure the safety of residents, there were no restraints in use at the time of audit. A comprehensive assessment, approval and monitoring process, with regular reviews, is expected to occur should a restraint be required. Staff undertake de-escalation training and reported a sound knowledge and understanding of restraint processes.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, data is analysed, trended, and benchmarked and results reported through all levels of the organisation. 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 | 43 | 0 | 1 | 1 | 0 | 0 |
| Criteria | 2 | 87 | 0 | 2 | 1 | 0 | 0 |

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

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>Talbot Park has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging residents' independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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 choices and give informed consent.</p> | FA | <p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>All residents' files reviewed, except for one, had EPOAs in place (refer criterion 1.3.1). Interview with the CNM, identified in regards to the resident with no EPOA in place, the family needed to apply to the court to be appointed the resident's EPOA. The family did not however have the required financial resources to do this. The psycho-geriatrician has verified the resident is required to be in a secure environment under the Code.</p> |

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| | | Staff were observed to gain consent for day to day care on an ongoing basis. Family members and EPOAs expressed satisfaction with the consent processes at Talbot Park. |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | FA | <p>During the admission process, residents, their EPOAs and family members are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Code were also displayed in the facility, and additional brochures were available at reception. Family members, EPOAs and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>Observation and Interviews with staff, family members and EPOAs provided evidence residents, EPOAs and family members are assisted to maximise their potential, and to maintain links with their family and the community by attending a variety of organised outings, attendance at church services, visits, shopping trips, activities, and entertainment.</p> <p>Talbot Park has unrestricted visiting hours and encourages visits from residents' families and friends. Family members and EPOAs remarked on how welcome they felt when they visited.</p> |
| <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>The organisational complaints management policy and process covers definitions of different types of complaints, notes the need to report all complaints through the quality management team and includes the complaints process and associated timeframes as applicable to Right 10 in the Code. A flow diagram also describes the complaints process step by step. Staff informed that a copy of the complaints policy and procedure is provided to family members on admission and those interviewed confirmed this and knew how to make a complaint. Updates on any concerns or complaints are provided in quality meetings, which have complaints as an agenda item. The charge nurse manager's quarterly reports include complaints as a topic and internal audits on their management (as applicable) are completed six monthly.</p> <p>A complaints register is in place and showed that only one complaint had been received since January 2017. Previous complaints that were documented in the register described the nature of the complaint, the follow-up processes, actions taken and notes on the agreed resolution. These had been completed within the required timeframes, with reasons provided for delays. More comprehensive supporting documentation was not available as it had previously been sent through to the District Health Board. Such information is now being entered directly into the District Health Board's electronic complaints management system.</p> |

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| | | <p>The charge nurse manager takes the lead in the complaints management process, supported by the service manager and the quality team of the South Canterbury District Health Board. Staff interviewed confirmed their understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit, although the charge nurse manager knew of a complaint that had gone direct to the District Health Board, rather than through Talbot Park, and this had been closed with a successful resolution.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>Residents, their enduring power of attorneys (EPOAs) and their family members reported during interviews they were made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</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> | FA | <p>Residents, their EPOAs and their family members confirmed that the services being provided by Talbot Park was considerate in regards to each resident's dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents have a private room.</p> <p>Residents are assisted to maintain their independence by Talbot Park staff enabling residents to participate in community activities, regular outings to the local shops or areas of interest. Each resident's care plan included documentation related to the resident's abilities, and strategies to maximise independence. The 'Maps of Life' in the residents' rooms, captures events in the resident's life and enable staff the opportunity to promote meaningful conversation around areas of interest. A number of residents had been shearers, and on days when it was wet and shearing would have been cancelled, these residents remain in bed and aren't disturbed till they wake up.</p> <p>The review of resident's files confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p> |

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| <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> | FA | <p>There is one resident at Talbot Park at the time of audit who identifies as Māori. Evidence is sighted of staff supporting this resident to integrate their cultural values and beliefs into their life at Talbot Park. The staff are observed encouraging the resident and participating in singing songs in Maori. The recent Matariki celebration has been recognised in the unit, with visits from the Maori mental health team members to add a cultural perspective to the weekly activities. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to all residents. There is a current Māori health plan developed with input from the SCDHB cultural advisors.</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> | FA | <p>Residents, EPOAs and family members verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A sighted resident, family member and EPOA satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | FA | <p>Residents, EPOAs and family members interviewed stated that residents were treated with respect and free from any type of discrimination, harassment or exploitation. Family members and EPOAs believed residents felt safe, by their observations of a relaxed environment with minimal evidence of residents being agitated. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | FA | <p>The service encourages and promotes good practice with input available from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, district nurses /wound care specialist, community dieticians, psycho-geriatrician and mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and</p> |

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| | | <p>appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive support from management and the South Canterbury District Health Board (SCDHB) to access external education, to support contemporary good practice.</p> <p>Examples of project overviews demonstrating good practice were reviewed and demonstrated continuous improvement around developing and implementing resident centred initiatives. Observations during the audit and documentation reviewed included a reduction in episodes of challenging behaviour by residents, a decrease in the use of anti-psychotic medication, an environment where residents were calm and relaxed and a positive response to the environment by families, EPOAs and staff.</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>Residents, EPOAs and family members stated they were kept well informed about any changes to their own or their relative's status, were advised promptly about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported by documentation in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via SCDHB when required. Staff knew how to do so. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</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>A strategic direction document for the South Canterbury District Health Board, for which the annual review has just been completed, has 'Every Moment Matters' as its vision. This applies to the staff, patients and the wider community. Five strategies to achieve the vision include productive partnerships, integrated person-centred care, valuing our people, health equity for all and fit for future. The mission statement is about enhancing the health and independence of the people of South Canterbury and the values include integrity, collaboration, accountability, respect and excellence.</p> <p>There are annual and longer-term goals and objectives for both Talbot Park and the overarching District Health Board to work towards achieving the vision and mission. Three examples of quarterly reports that are provided to District Health Board managers were sighted and demonstrated a range of information is contributing to monitoring performance of the service. This information included occupancy, staffing, quality management monitoring processes, management of emerging risks, incident management and operational data. These are reportedly summarised for presentation to the Board members.</p> <p>A charge nurse manager is responsible for the management of Talbot Park and has been in the role for approximately five years. Support and oversight is provided by a service manager, who was interviewed during the audit. Both managers are registered nurses who are maintaining their annual practising</p> |

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| | | <p>certificates and have a number of years management experience. The charge nurse manager has completed professional development specific to management within the aged care sector and demonstrated knowledge of the sector, regulatory and reporting requirements. Responsibilities and accountabilities are defined in a job description and individual employment agreement, which was viewed.</p> <p>The service holds District Health Board contracts under the Aged Residential Hospital Specialised Services Agreement. Although the unit has 25 beds available for the provision of specialised psychogeriatric care and support, only 18 were occupied on the day of audit. There is one person under the age of 65, however they are funded under the same contract as all other residents. Staff have all completed dementia training, as required in the agreement and the person/family centred approach is so strong that continuous improvement in this area is acknowledged in standard 1.1.8: Good Practice.</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> | FA | <p>In the absence of the charge nurse manager, the facility is managed by a senior registered nurse (the most senior and longest serving in the service) with oversight from the service manager. The relief manager carries out all the required duties under delegated authority.</p> <p>As both the charge nurse manager and the service manager are registered nurses with current practising certificates, the clinical management oversight is completed by the service manager. The service manager is experienced in the sector and able to take responsibility for any clinical issues that may arise in order to support the relief registered nurse. Staff confirmed that they feel supported and that the current management system is working well, despite the restructuring underway as directed from senior management of the district health board.</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> | FA | <p>A South Canterbury District Health Board quality and risk management plan, which reflects the principles of continuous quality improvement is in place. Talbot Park implements this within the facility and the charge nurse manager attends related meetings. The quality plan and quality activity matrix are reviewed annually, two monthly continuous quality improvement meetings occur and quarterly reports on quality related issues are developed. Examples of topics covered include complaints management, internal audits and monitoring processes, management of incidents and accident reporting, health and safety and infection reporting, staff feedback, family survey responses and residents' reviews. Meeting minutes reviewed confirmed implementation of the quality plan.</p> <p>A comprehensive quality activity and internal audit matrix was sighted for July 2017 – June 2018, as was a new matrix for the upcoming year. An accompanying comprehensive range of internal monitoring tools and processes to support the different topics are also available. The range of documentation sighted confirmed that the service provider is demonstrating continuous improvement for the manner in which</p> |

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| | | <p>they are developing quality improvement initiatives in response to identified gaps and/or identified areas for improvement. These initiatives have also developed from corrective action plans implemented because of the ongoing quality monitoring systems.</p> <p>Staff informed during interviews that they receive updates on the quality management topics via monthly staff meetings and in quality committee meeting minutes that they are requested to read and sign.</p> <p>Policies reviewed as part of stage one audit cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility assessment tool and process. Policies are based on best practice and were current. The document control system is undertaken at District Health Board level and ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. There are additional, or supplementary documents that specifically focus on Talbot Park.</p> <p>Family satisfaction surveys are completed annually. The most recent survey was undertaken June 2018 via telephone contact with an invitation for additional written feedback. Results showed family members are overall satisfied, they acknowledged that open disclosure is consistently occurring, noted the food is good with plenty of variety, stated that restraints of any form are not used, expressed appreciation for the different quality improvement projects that have been implemented and made comments about the older buildings, that sometimes clothing becomes shrunk and sometimes clothing items get mixed up with other residents' items of clothing.</p> <p>The charge nurse manager and the service manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. As for other quality management issues, there are both District Health Board and Talbot Park specific risks that are being managed. The service manager and the charge nurse manager have attended relevant training and is familiar with the Health and Safety at Work Act (2015). Requirements are being implemented accordingly. Reviews of the health and safety system are completed every three months and reported back to the District Health Board Health and Safety Committee. This process includes reviews of hazard management and the hazard register and reports on the quarterly health and safety internal audits.</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</p> | <p>FA</p> | <p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported through the quality committee both within Talbot Park as well as through the South Canterbury District Health Board. Further discussion is undertaken at shift handovers and again at staff meetings. Monthly 'Safety First' reports are developed and copies of these were sighted. Corrective actions are being developed and implemented as indicated and the information obtained is being used for quality improvement processes to reduce the likelihood of a recurrence. During a management review of Safety First reports</p> |

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| <p>appropriate their family/whānau of choice in an open manner.</p> | | <p>for patterns and trends, it was found that there had been an increase in the number of safety and behaviour incidents and employee incidents. As described in criterion 1.2.3.6 above, a comprehensive review was undertaken to address areas identified for improvement.</p> <p>The charge nurse manager described essential notification reporting requirements. She advised there has been one recent notification of a significant event made to the South Canterbury District Health Board and the Ministry of Health. Not all documentation for this was available as the District Health Board has yet to complete their investigation; however, the information that was available and reports from the charge nurse manager and the service manager confirmed efforts have been made to ensure this does not happen again. The person concerned is no longer at this facility. There have been no Health and Disability Commissioner complaints, police investigations, Coroner's inquests, issues based audits or any other notifications required since the last audit.</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>All registered health professionals have their qualifications checked when they commence employment. Copies, or evidence of, annual practising certificates have been obtained for all such professionals who have contact with residents. A register confirming this was sighted and included allied health professionals and general practitioners. Seven of the eight registered nurses working at Talbot Park are maintaining their annual competency requirements to undertake interRAI assessments.</p> <p>South Canterbury District Health Board's recruitment and selection policy and procedures are based on good employment practice and relevant legislation. They describe the approval of vacancy and advertising processes, management of applications, short-listing as per pre-determined criteria, interviewing and pre-employment checks that include health and safety, police vetting, verbal reference checks, plus the person's right to work in NZ. The charge nurse manager informed how the processes at Talbot Park are undertaken according to these requirements and staff files reviewed included documentation that was consistent with requirements.</p> <p>An organisation wide policy and procedure on orientation is District Health Board focused. This describes both the orientation and induction processes and the responsibilities of human resources, staff development, line managers and employees. All staff files reviewed included copies of completed orientation and induction processes at both Talbot Park and for the overarching District Health Board. Copies of three-month performance reviews were also in the files for more recently employed staff. During interviews, staff informed that the topics covered are applicable and noted that the time being 'buddied' over three days is important for new staff. The charge nurse manager explained that the full orientation process takes an average of three months.</p> <p>Documentation on learning and development requires all staff to undertake mandatory training and participate in ongoing training as scheduled. Continuing education is planned on an annual basis. A spreadsheet detailing the record of learning for each staff person is in place and was sighted. All annual</p> |

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| | | <p>training update requirements are being met with the exception of three very casual staff and one on maternity leave. The mandatory training includes the requirements as listed in the contractual agreement. Opportunities to attend external training are offered and funding towards qualifications may be made available on application. For registered nurses and managers, the annual performance appraisals, which are being completed for all staff, guide the person's professional development plan. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the District Health Board. All staff have completed the required education in relation to dementia care except for one person who is completing the last paper.</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>There is a South Canterbury District Health Board rostering policy, with additional guidance notes for Talbot Park that are specific to the facility. This document requires that rosters reflect appropriate staff skill mixes and staff numbers and described actions to be taken in the event of staff leave and absences. These guidelines are intended to ensure safe service delivery over 24 hours a day on seven days a week will be provided.</p> <p>The facility is implementing the policy and guidelines and examples were provided that showed the charge nurse manager is adjusting staffing levels to meet the changing needs of residents. There is on call support available and staff reported that good access to advice is available when needed with one or more registered nurses always being on duty. Family interviewed are satisfied with staffing levels. Observations made and review of a four-week roster cycle (for pre and post audit timeframes) confirmed adequate staff cover is being provided. Staff are being replaced in any unplanned absence. All staff complete resuscitation support training, rather than first aid, and although some staff are in the three-month leeway time and are due to renew this, all registered nurses have a current certificate. As mentioned in Standard 1.2.7, all staff have completed dementia training and registered nurses have current interRAI competencies.</p> <p>The roster showed that in addition to the registered nurse and the charge nurse manager, six healthcare assistants work various hours in the morning shift over seven days a week; four cover the afternoon shifts and two the night shift. Currently Talbot Park is staffed for 25 residents; however, an occupancy rate of only 18 – 20 has been occurring for the past 12 months. District Health Board authorised plans to reduce staff numbers were sighted. It is intended that from 20 August 2018 staff numbers will more accurately reflect the occupancy of up to 20 beds. The documentation states that additional staff may be requested in response to increased acuity and who will be responsible for the decision making about this. During interviews, health care assistants reported there is currently adequate staff available to complete the work allocated to them, although expressed fears that the proposed changes may compromise this. All interviewed confirmed they have been fully informed about the planned changes and that they had been assured additional staff will be provided when acuity increases, or bed occupancy goes above 20.</p> |

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| <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> | <p>FA</p> | <p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records of present residents are held securely on site. Records of residents no longer residing at Talbot Park are held offsite at SCDHB. All records are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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> | <p>FA</p> | <p>Residents enter the service when their required level of care has been assessed by the psycho-geriatrician and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents, their EPOAs and/or their families are encouraged to visit the facility prior to admission and meet with the charge nurse manager (CNM). They are also provided with written information about the service and the admission process.</p> <p>The files of all residents reviewed evidenced an assessment by the psycho-geriatrician verifying the need for care in Talbot Park. All residents' files reviewed, except for one had an EPOA in place. The file of the resident with no EPOA in place had documentation from the psycho-geriatrician, verifying the need for placement.</p> <p>Family members or EPOAs interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with 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> | <p>FA</p> | <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the SCDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. Interview with the EPOA of a resident previously requiring transfer for allied services input, identified being kept well informed during the transfer process.</p> |

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| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | <p>FA</p> | <p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using a manual system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the three-monthly medicine review chart.</p> <p>Medication errors are reported to the CNM and recorded on an accident/incident form. The residents designated representative is 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 meet standing order 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> | <p>PA Moderate</p> | <p>The meals for residents of Talbot Park, are cooked offsite at the SCDHB by a contracted food service provider, and delivered to Talbot Park each meal time, on insulated trays. There are also additional supplies of food on site, to enable staff to provide residents with additional food if required at any time.</p> <p>The menu follows summer and winter patterns. At the time of audit there was no evidence available to indicate that the winter menu is in line with recognised nutritional guidelines for older people. This was sent several days after the audit; however a corrective action had already been raised.</p> <p>A food control plan was sighted, and documentation verified the plan was registered with the Ministry of</p> |

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| | | <p>Primary Industries (MPI) in September 2017. The plan is due to expire in September 2018. Documentation evidences an external audit is booked to occur 16 August 2018.</p> <p>The food arrives at Talbot Park in insulated trays on an enclosed trolley, however the temperature monitoring records of the food when it is checked at Talbot Park, prior to being given to the residents, shows the temperature is not at the required temperature.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to the food service provider and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by residents, EPOA and family interviews and satisfaction surveys. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. No dissatisfaction was expressed around the temperature of the food. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</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>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident/EPOA and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNM. There is a clause in the access agreement related to when a resident's placement can be terminated.</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 to Talbot Park, residents are assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, behaviour assessment, nutritional screening and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents an InterRAI assessment is undertaken to inform the long term care plan. Ongoing reassessment using the interRAI assessment tool and any required additional tools, occurs every six months or more frequently as residents' changing conditions require.</p> <p>In files reviewed, initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six-monthly unless the resident's condition changes. Interviews, documentation and observation identified the RNs understand the requirement for reassessment of a resident using the interRAI assessment tool when a resident has</p> |

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| | | <p>increasing or changing need levels.</p> <p>All files reviewed have current interRAI assessments completed by seven of eight RNs who are trained interRAI assessors. InterRAI assessments are used to inform the care plan.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments are reflected in the care plans reviewed. All files reviewed had behaviour management plans in place that included the type of behaviour, triggers to the behaviour and management strategies to deescalate the behaviours.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Family members and EPOAs reported participation in the development and ongoing evaluation of care plans.</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> | FA | <p>Documentation, observations and interviews verified the provision of care provided to residents of Talbot Park was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in service provision. The environment was calm and relaxed with no evidence of disruptive behaviours. Residents were engaged and participating in the activities being provided. Staff responded promptly to residents' requests for 'a cup of coffee' and assisted residents when required. Staff were observed to be perceptive to potentially disruptive events and implemented de-escalation strategies.</p> <p>The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to hospital level dementia care and in accordance with 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</p> | FA | <p>The activities programme is provided by a trained diversional therapist.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Each resident has a 'map of life' that identifies a vast range of factors important in the resident's life, and a wellbeing plan that identifies the resident's activity, social, physical, psychological, spiritual and cultural needs over the 24 hour period. Activities assessments and wellbeing</p> |

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| <p>are appropriate to their needs, age, culture, and the setting of the service.</p> | | <p>plans are regularly reviewed to help formulate an activity programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included twice weekly outings to participate in the community and visits from community groups. Recently Matariki was celebrated with members of the Māori mental health unit coming and entertaining the residents. Visits from local dance groups, school groups, visiting entertainers, quiz sessions and daily news updates are also included in the activities programme.</p> <p>There are no regularly scheduled resident/EPOA/family meetings as attendance to the meetings was minimal due to a lot of family members living out of the area. The activities programme is discussed informally with the residents and their EPOAs or family members when they visit, and any suggestions are greatly received.</p> <p>There are a wide range of resources within the unit that enables the resident to engage. Strategically placed posters around the unit, provide instruction/guidance and interaction with specific residents around their areas of interest (e.g., one resident has directions for specific exercises, another has questions to answer on an area of interest.) Each resident's room has the 'map of life' displayed, which helps to alert caregivers to topics of conversation that can be had with the resident.</p> <p>Family member and EPOA, satisfaction surveys demonstrated satisfaction with the services the unit provides. Residents, their EPOAs and families interviewed confirmed they find the programme meets their needs.</p> |
| <p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>FA</p> | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections, pain, weight loss, and behaviours, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. EPOAs and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> |

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| <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. Although the service has a main medical provider, residents may use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident, EPOA and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>An organisation wide waste management policy and procedure has a philosophy of waste minimisation and emphasises the need to segregate different types of waste and notes how each is to be managed. These include management of general waste, infectious waste, sharps and confidential information, for example.</p> <p>Staff follow these documented processes for the management of waste and infectious and hazardous substances. Overall waste is managed via external contractors and staff from Timaru Hospital. Chemicals are supplied by external laundry and cleaning contractors and the managers of these contracts were interviewed during the audit. Material safety data sheets are available, and staff receive training on their use. The contractors oversee the chemical safety requirements including regular audits. Staff interviewed knew what to do should any chemical spill/event occur, and a spill kit was sighted.</p> <p>There is provision and availability of protective clothing and equipment including gloves, plastic aprons, goggles and face shields and staff were observed using this. Staff have received recent reminders of the advantages of using face shields.</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 with an expiry date of 1 December 2018 is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Hot water temperature testing is consistently being checked monthly to ensure residents' safety. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Documentation from the check of the wheelchair weighing scales stated they had failed compliance; however, a sticker on them stated they had passed. Confirmation from the company concerned was not available and during the audit, a manager arranged for a new set to be purchased to ensure equipment safety and accuracy. Efforts are made to ensure the environment is</p> |

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| | | <p>hazard free, that residents are safe and independence is promoted. All areas were presented as clean and tidy on the day of audit.</p> <p>There is a documentation system for maintenance tasks. On review it was found that some several months old had not been signed off, despite the staff concerned able to demonstrate these had been completed. Prior to the end of the audit, the maintenance manager had implemented a more efficient and accountable system that will facilitate the sign off of these tasks.</p> <p>External areas are safely maintained and are appropriate to the residents living at Talbot Park. Environmental restraints that include key pads being on external doors and fenced courtyards being in place, ensure residents' safety. Security has been further reviewed since an incident of a breach of security, as noted in standard 1.2.4. The external courtyards are accessible to residents who may go in and out as they choose during daylight hours. Suitable outside seating and gardens enhance the enclosed external courtyards.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</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> | FA | <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes four toilets, two stand-alone showers, two other showers combined with a toilet and one shared ensuite between two rooms. All shower rooms are large with easy to manage equipment within them. There is a bathroom that has a bath with a hoist; however due to the hoist no longer working the room is locked and has been delegated for a store room.</p> <p>Non-slip flooring, and appropriately secured and approved handrails are installed in the toilet/shower areas. Other equipment/accessories including shower chairs and bath trollies are also available.</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> | FA | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms are large and provide single accommodation only. Rooms are personalised with furnishings, photos and other personal items displayed. Due to the problem of some residents uplifting items that do not belong to them, the staff have found ways to secure some of these items into position. They have also placed pictures relevant to earlier phases of the residents' lives to make it easier for them to identify their own rooms.</p> <p>There is room to store mobility aids and wheel chairs. Staff and family members reported the adequacy of bedrooms. Documentation sighted showed that previous family members have expressed appreciation</p> |

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| | | for use of a palliative room that has been established for use when a resident is receiving end of life care. |
| <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> | FA | <p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required, and can move outside from these rooms if they choose. Furniture is appropriate to the setting and residents' needs, with a variety of options available to meet individual preferences. A separate relaxation, family/whānau room outside of the locked doors is available for use when visitors/family members visit. This room is suitably furnished, enables additional privacy and has access to tea and coffee making facilities.</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> | FA | <p>Towels and bedlinen are laundered off site by a contracted provider. Personal items are also laundered off site, although some items are laundered on site by staff, or family members may take some home to launder. The laundry contract manager was interviewed during the audit and described the processes undertaken to ensure good care is taken of residents' clothes. Family members had commented in some survey results sighted about clothes being shrunk, or in need of repair. The manager described systems now in place to reduce such incidences. Care staff, as well as those with allocated laundry duties, are provided with relevant training. An awareness of accepted laundry processes was evident with reports of dirty/clean flow practices and correct handling of soiled linen. Family members interviewed reported the laundry is mostly managed well with few problems now compared with earlier times. Clothes are reportedly returned in a timely manner.</p> <p>Cleaning services are provided by an external contractor and the manager of this contract was also interviewed. There is a small designated cleaning team who have received appropriate training, as per the contract. Chemicals come up from Timaru Hospital as required, were stored in a lockable cupboard and were in appropriately labelled containers. The supplier is responsible for ensuring material data sheets are available and these were sighted.</p> <p>Cleaning and laundry processes are monitored six monthly through the organisation's internal audit programme as well as through the contractor's two monthly audits. Copies of results of these were sighted and showed 100% compliance for the last three audits. There were no corrective actions identified in the last two internal cleaning audits. The contract manager described a new system about to be implemented that focuses on key performance indicators. It was noted that these will form the basis of future cleaning staff performance appraisals, as well as for cleaning audit purposes.</p> <p>Family members noted that although the facility is older style, the place is always clean and there are not any offensive odours.</p> |

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| <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>PA Low</p> | <p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. All such procedures meet the needs and will maintain the safety for hospital level care residents with dementia. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. Emergency lighting and fire safety equipment is regularly tested by a contractor and records confirming this were sighted. Lighted exit signs that were missing have been installed. The current fire evacuation plan was approved by the New Zealand Fire Service on 5 March 1996. A trial evacuation takes place six-monthly with the most recent being 28 November 2017 and 28 May 2018. The orientation programme includes fire and security training, which is also a component of the ongoing mandatory annual training programme. The administrator/reception person is the fire safety officer and during interviews, staff confirmed their awareness of the emergency procedures.</p> <p>Alternative energy and utility sources are available with adequate supplies of water for use in the event of a civil defence emergency available in on-site water tanks. There is a generator on site that is checked by maintenance staff. Food and miscellaneous emergency supplies are in a hallway cupboard. Although evidence was sent of actions taken after the audit; at the time of audit there was a need for improved management of the emergency supplies and of equipment, such as radios to be used in an emergency, which has been raised for corrective action.</p> <p>Call bells alert staff to residents requiring assistance. Staff informed that because residents seldom use them they are especially alert to them when used.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at least three times a night. Records of each visit are entered into a book near an entrance beside the maintenance shed and when viewed, this confirmed consistency of checks occurring.</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> | <p>FA</p> | <p>All residents' rooms and communal areas are heated with water filled radiators and ventilated appropriately with windows with security latches. Shower rooms have fans in place. Bedrooms have natural light coming through openable external windows and communal rooms have doors and windows that can be opened. Only service rooms do not have natural light coming through windows to the outside.</p> <p>Areas were warm and well ventilated throughout the audit and families confirmed the facilities are maintained at a comfortable temperature and never cold in winter.</p> |

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| <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> | <p>FA</p> | <p>Talbot Park 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 (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed by SCDHB with input from the CNM. The infection control programme and manual are reviewed annually.</p> <p>The CNM is the designated infection control nurse (ICN) whose role and responsibilities are defined as part of the CNM job description. Infection control matters, including surveillance results, are reported monthly to the service manager (SM) and tabled at the monthly multidisciplinary and staff meetings. Infection control statistics are recorded, analysed, graphed and displayed in the staff room. Any infection control concerns are directed through the SM to the SCDHB infection control co-ordinator (ICC).</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | <p>FA</p> | <p>The infection control nurse (ICN) has appropriate skills, knowledge and qualifications for the role and has undertaken post graduate training in infection prevention and control and attended relevant study days, as verified in training records sighted. The ICN is supported by the ICC at SCDHB. The ICN has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The audit schedule includes ongoing audits around IPC policies.</p> <p>The ICN/CNM confirmed the availability of resources to support the programme and any outbreak of an infection. There have been no norovirus outbreaks at Talbot Park in the past 18 months.</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</p> | <p>FA</p> | <p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p> |

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| <p>policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</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> | <p>FA</p> | <p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the ICN and ICC at SCDHB. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</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>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICN/CNM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via multidisciplinary and staff meetings and at staff handovers. Surveillance data is entered in the organisation's infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p> <p>A 2017-2018 analysis of infection data identified a low rate of urinary tract infections (UTIs) and antibiotic use at Talbot Park.</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>Policies and procedures on managing challenging behaviours include definitions and describe topics such as behaviour assessment, observations, management plans and inclusion in residents' care plans. De-escalation techniques are described, and staff have completed non-violent crisis intervention training.</p> <p>Restraint minimisation policy and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints. They include definitions</p> |

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| | | <p>of enablers and various types of restraint. Due to the fact that all residents have been assessed as requiring hospital level dementia care, enablers would not be used in this facility as they are unable to make an informed choice. The documents address assessment, monitoring and evaluation processes for any use of a restraint. Facility approved items for restraint, once an assessment has been completed, are a seat belt with a leg and waist strap, a lap belt with leg straps or a lap belt.</p> <p>The restraint coordinator/charge nurse manager provides support and oversight for restraint management in this facility and demonstrated a sound understanding of the role, responsibilities and the organisation's policies, procedures and practices. Records sighted showed that staff receive restraint minimisation education every two years, in addition to the training on communication and de-escalation, via Health Learn. Quarterly audits of restraint use are required to be undertaken for the quarterly reports.</p> <p>On the day of audit, there were no residents using any form of restraint. The last restraint use was in August 2017, which was confirmed in the restraint register and in the copies of the quarterly reports sighted.</p> <p>Staff interviewed confirmed they do not use restraints in this facility and would only do so as a last resort and if directed by a registered nurse.</p> <p>The use of environmental restraint for the safety of all residents is described in organisational service descriptions and in the restraint minimisation and safe practice policy documentation.</p> |
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Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Low | The food service is prepared offsite by an external food service provider at SCDHB and delivered to Talbot Park residents. The food service provider was unable to verify the current winter menu meals have been reviewed by a qualified dietician and are in line with recognised nutritional guidelines for older persons. Evidence suggests satisfaction with the meals provided. | The current winter menu in use has no evidence to verify it has been reviewed by a qualified dietician and that it is in line with recognised nutritional guidelines for older people. | Provide evidence the winter menu being provided to residents of Talbot Park meets nutritional guidelines for older people. 30 days |

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| <p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p> | <p>PA Moderate</p> | <p>The food arrives at Talbot Park each meal time on insulated trays on an enclosed trolley, after having been prepared at the SCDHB kitchen. When the food arrives the care staff check the temperatures of the food prior to handing out the trays to residents, to ensure it is above a requested 60-degrees Celsius (°C). Records of the food temperature recorded on the day of audit, and the preceding three months, identified only twice has the food temperatures been greater than 60°C. Incident forms and emails verify ongoing concerns expressed by Talbot Park staff to the SCDHB and food service provider regarding the temperature of food not meeting the required standard when it arrives at Talbot Park. While some attempt has been made at rectifying the problem, this remains unresolved.</p> | <p>The temperature of the cooked food is not being maintained at the requested 60°C, before being provided to residents.</p> | <p>Provide evidence cooked food temperatures remain above 60°C.</p> <p>30 days</p> |
| <p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p> | <p>PA Low</p> | <p>Civil defence supplies were in a locked hallway cupboard. A range of items for use in an emergency were on various shelves and some hidden under other items. These included canned and packet food, batteries, a wind-up radio and continence supplies, for example. Heavy boxes of what might have been canned food were on a top shelf with poor access in the event of an emergency. There was a lack of awareness by staff and managers as to what items were available, quantities in stock, who is responsible for managing the supplies and generally how these were managed. No checklist was available and no evidence of a recent check of emergency supplies was able to be provided for review. Although the risk has been rated as moderate, the timeframe has been reduced to 30 days for the service provider to action to ensure this is addressed in a timely manner.</p> | <p>Items that contribute to the civil defence kit are in different places, there is no check list available as to what items are to be present and there was no evidence of ongoing monitoring of the contents.</p> | <p>Appropriate equipment and supplies are available to respond to emergency situations.</p> <p>30 days</p> |

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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 |
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| <p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p> | CI | <p>The use of continuous quality improvement processes has been raised as a CI under quality management 1.2.3. Project overviews/summaries that demonstrated good practise were reviewed. Some of these initiatives were in response to issues identified as needing improvement during internal audits, management reviews, family feedback processes and ideas from new staff. Examples are described below:</p> <ul style="list-style-type: none"> • Map of Life: This project, started in 2016 due to staff wanting more information about the residents they care for. The manager and senior staff developed a template intended to be used to gain a profile of each person from when they arrive at the service. This documented template has progressively developed to now include a diagrammatic format with different coloured boxes representing different aspects of the person's life and a short comment in each pertaining to the resident (e.g., children and grandchildren, working life and special interests). Reviews in 2017 and 2018 have seen the development of various formats and staff are encouraged to read parts of these each day. Staff feedback has been positive about how much more they know about the residents, that they read one or two boxes and use the information to start a conversation with the person while providing care and support. Family have fed back that they enjoy reading these to remind themselves of their loved one's journey, that they appreciate that staff use them and have used the | <p>Talbot Park demonstrates a commitment to good practice, focussing on implementing resident centred initiatives to improve resident centred care.</p> |

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| | <p>term resident centred. The importance of these has been acknowledged and allocated staff are given a timeframe to complete them and they are now required to be completed within one week of admission. A progression to relevant pictures on residents' doors that reflect the profile is a more recent step and a recent review has identified that the pictures are assisting residents to find their own room resulting in a decrease in the number of people going into others' rooms. The information above shows that development of the Map of Life initiative has occurred because of ongoing reviews.</p> <ul style="list-style-type: none"> • The Wellbeing plan format: Changes have been made to the wellbeing plan in consultation with the diversional therapist (DT) in particular to ensure it was resident centred and more accurately reflected their backgrounds, rather than just what the facility programme was. Family members were involved in the review of these and have been proactive in ensuring increased accuracy of the information. As a result, family are being more involved, and the latest review concluded it has become increasingly user-friendly and more appropriate for individuals than previous plans. • Meaningful indoor incidental activities: In September 2016, the organisation was challenged due to indoor activities not being meaningful to the residents. A concerted effort was then made to provide new opportunities. This has continued to evolve with community groups involved in the making of some of these. It was then identified that there were insufficient 'blokes' activities. As a direct result, there are now multiple types of tactile and fiddle boards that are either fixed or mobile, include boards and cushions with padlocks, cords, slide bolts, pom poms, laces and quilts. New ideas are being introduced, more resources are going into developing them and they are being reviewed for safety, durability and popularity/preferred use by residents. • Creation of a palliative room: Previously, end of life care was undertaken in the hospital wing. Once this was closed the manager and staff felt a dedicated room was needed for this purpose to enable families and the resident to participate in this process in the manner they are most comfortable with. The room is light, has a calm feeling, has an aromatherapy mister and is appropriately furnished. It was reported that personal belongings are taken in there and every effort is made to make the environment as applicable to the individual resident and family as possible. Over time it has been found that not all families have chosen to use it but there was documented evidence sighted that when loved ones die, one of the common messages the service provider receives is about the value of this room and how special it was. • Relaxation room: There was an identified need for an area for residents to go to with family when families are not able to take the person out. A relaxation room was developed as a space for families to go with their loved one away from the busyness of the unit. There are tea and coffee facilities and residents may eat there with family members. The manager noted that a review showed an increase in its use and positive feedback from families when interviewed. Staff reported that residents who used it often returned very calm and | |
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| | | settled. Following evaluation of the idea it was decided to move it closer to the wing and this has seen its use increase further. An unintended consequence has been its use as a family/whānau room when family members require some private time, or a resident is unwell or dying. | |
| <p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p> | CI | <p>Throughout the audit there was increasing evidence of targeted quality improvement initiatives and projects that have been developed. These are a result of issues raised during the process of addressing internal and externally generated corrective actions, or feedback from one or more people. A folder of these projects was reviewed and a theme coming through was the strong focus on resident-centred care and support, which has been identified as a feature in its own right that is demonstrating continuous improvement under Good Practice, criterion 1.1.8.1.</p> <p>Examples of quality improvement initiatives over the past 12 months, in addition to those noted in 1.1.8.1, were in relation to regular checking syringe driver components to ensure it is ready for resident care should it be needed, a review of continence products to improve residents' comfort, improving the identification and planning of spiritual/cultural aspects of residents' care, the analyses of falls to reduce incidence with the type of sensor mats changed that has since reduced the frequency, and a review of residents' weight and their nutrition resulted in more individualised meals.</p> <p>Of particular note, is a report on Talbot Park written by the service manager that includes background, methodology, evaluation/review processes and a set of six week, three month and six month time-framed recommendations. The investigation process and report were prompted by a quality management system review outcome. An analysis of the incident (Safety First) reports showed that there had been an increased number of safety and behavioural incidents and employee incidents. The management team proposed and commenced a two-and-a-half-day comprehensive review/internal audit of a range of aspects of the service delivery and functioning of Talbot Park. The review covered staff motivation and morale, a more in-depth review of incidents January 2017 until April 2018, admission history of residents and the processes used, residents' file reviews, residents' activities, specialist support availability, family feedback, policies and procedures, education, the quality plan, end of life, management of the unwell or complex care resident and maintenance of the grounds and buildings. Summarised outcomes are described in the report and are followed by the time-framed recommendations. All of the short-term recommendations, many of which have had positive impacts on residents' care and support, have been completed with evaluation of their effectiveness being fed back in staff and quality meetings and through family feedback. Progress is underway for the three-month recommendations and several of the six-month recommendations have also been commenced. The recommendations demonstrated pragmatism with intentions to improve the care and support provided to residents, their lifestyles and the environment.</p> <p>Without prompting, family members have volunteered affirmative comments about these initiatives, mention has been made of their value in the survey results and feedback sought as part of each initiative</p> | <p>There is a responsive culture of continuous quality improvement within this service, which is seeing a range of initiatives that are consistently enhancing the quality of life for residents being planned, implemented and evaluated. Changes are being made as indicated.</p> |

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| | | <p>included appreciation about the benefits for their loved ones. Staff informed that they feel heard and have appreciated being involved in the improvements underway.</p> <p>This criterion has been allocated a continuous improvement rating, not only because of the number of initiatives implemented to improve resident related issues, or staff related issues that have the potential to impact positively on residents' care, but also for the use of quality improvement processes to identify and address shortcomings and implement potential improvements.</p> | |
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End of the report.