

St Clair Park Residential Centre Limited - St Clair Park Residential Centre

Introduction

This report records the results of a Partial Provisional Audit; 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 Health and Disability Auditing New Zealand 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: St Clair Park Residential Centre Limited

Premises audited: St Clair Park Residential Centre

Services audited: Rest home care (excluding dementia care); Residential disability services - Psychiatric

Dates of audit: Start date: 19 July 2018 End date: 20 July 2018

Proposed changes to current services (if any): The service is adding dementia level care to their current certified services. The dementia unit is a 13-bed secure unit. HealthCERT letter dated 3 April 2018 stated due the urgent need of placement for people with dementia approval is given for the service to utilise the new facilities

immediately. There are currently three residents in the unit.

Total beds occupied across all premises included in the audit on the first day of the audit: 29

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

St Clair Residential Park is privately owned. The service is certified to provide rest home and residential disability (psychiatric) level care for up to 41 residents. On the day of the audit there were 29 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, families, staff and management. A concurrent partial provisional audit was also conducted to verify a 13-bed unit as suitable to provide dementia level care. The service received HealthCERT approval to open the unit for a period of 3-months due to the urgency of beds prior to the audit.

St Clair is managed by a non-clinical manager with experience managing health services and who has been in the role since December 2017. The manager is supported by a registered nurse (RN) with six years aged care experience and who has been in the position for four months. Feedback from residents and families was positive about the care and services provided.

This audit has also identified that improvements are required around the resident advocacy information, informed consent and admission agreements, complaints register, business plan, quality system, resident and family input, staff training, orientation, performance appraisals, staffing, interventions, evaluations, temperature monitoring, hot water, smoke-free policy and civil defence supplies.

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.		Some standards applicable to this service partially attained and of low risk.
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Resident information packs include specific information such as the Code of Rights, advocacy services and complaints processes. Interviews with residents demonstrated they were provided with adequate information and that communication is open.

All residents have cultural needs identified where these exist. Open disclosure is practiced and appropriate communication with residents and families/whānau is implemented. There are documented informed consent processes. Links with family/whānau and other health providers in the community are maintained. There is a complaints policy.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Services are planned, coordinated and are appropriate to the needs of the residents. The manager and RN are responsible for the day-to-day operations of the facility. The manager writes a weekly report to the owner which contains quality data. The manager

and RN meet weekly and discuss incidents and infection control. There are regular resident meetings and resident/management meetings. There are policies to support consumer and family involvement at all levels of the service.

Falls prevention strategies are in place. There are human resources policies in place, including recruitment, selection, orientation and staff training and development. There is a documented training plan.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The registered nurse is responsible for each stage of service provision. The assessments, initial and long-term nursing care plans are developed in consultation with the resident/family/whānau. The residents each have a care plan, and these are reviewed at least six monthly or earlier if there is a change in health status.

The activity programme is developed to promote resident independence and social interaction. Residents interviewed spoke positively about the activity programme.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies. Medications are stored appropriately.

Meals are prepared off-site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Residents interviewed were complimentary about the food service.

Safe and appropriate environment

<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 medium or high risk and/or unattained and of low risk.</p>
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The building at St Clair Park has a current building warrant of fitness. Procedures are in place for emergencies, laundry use and safe management of waste and hazardous substances. Maintenance systems are in place. Protective gloves, glasses and spill kits are available. The building is appropriately heated and ventilated. Residents interviewed stated bathroom, personal space areas, outside and communal areas are suitable for their needs. There are processes in place to ensure a safe environment for residents, staff and visitors that are appropriate to the service delivery setting.

Partial provisional: An existing wing has been allocated to the dementia unit. Resident bedrooms are personalised with access to communal facilities. Residents can freely mobilise within the communal areas with safe access to the secure outdoor area with seating and shade

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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St Clair Park has a no restraint policy in place. Staff receive training in restraint minimisation and challenging behaviour management. The service maintains a restraint free environment and no enablers were in use.

Infection prevention and control

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

Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Education is an area for improvement. The type of surveillance undertaken is appropriate to the size and complexity of the facility.

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	33	0	11	4	0	0
Criteria	0	97	0	15	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	Interviews with staff (four support workers, the activities coordinator, clinical leader, registered nurse and manager) and documentation confirmed that St Clair Park delivers a service that is focused on the health, wellbeing and cultural needs of its residents. Staff can describe resident's rights as per the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). The Code was displayed in poster form in English and Māori in the residents' communal areas. Copies of the Code are given to all new residents. Staff receive orientation and ongoing training on consumer rights (link 1.2.7.5).
<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</p>	PA Low	Each resident receives an admission pack prior to admission to the facility. Current advance directives and CPR decisions are on all resident files reviewed. Medically initiated not for resuscitation forms are completed by the GP on admission for residents who are not able to make decisions independently. If the resident is able to make informed decisions, the resident has signed the form indicating their decision around resuscitation, this is witnessed by the general practitioner (GP) and registered nurse. Resuscitation forms are reviewed annually. Consent forms sighted are signed by the resident or Enduring Power of Attorney (EPOA). Not all resident files reviewed had a signed admission agreement or consent form. Relatives interviewed felt they were well informed on admission to the service.

consent.		
<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>The complaints policy includes the requirement that residents are informed about accessing independent advocacy services for support during complaints processes. Information about the Nationwide Health and Disability Advocacy Service is brought to the resident's attention on admission (link 1.1.2.4). Residents receive an information pack that includes advocacy services and information relating to the Code, which included reference to advocacy services on admission. Residents confirmed that they were aware of the process of how to access advocates should they have a need to.</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>The service encourages and welcomes family support with resident's consent. Residents can meet family/whānau within their home environment and have links within the community such as access to education, and practise of religious belief. Community events are encouraged and supported for residents to attend to be active in the community. The resident information pack has clear guidelines for visitors, entry into the premises and what cannot be brought onto the premises. Residents interviewed stated they access other services in the community for various reasons and are assisted to do so by staff as relevant to their health and wellbeing. The service provides assistance to ensure residents are able to participate in as much as they can safely and desire to do. This includes resident's visits to the local mall, visiting the library and attending community groups.</p> <p>MHA: Information is provided to family/whānau. The role of family/whānau and support available to them is contained in the resident's information pack. This is discussed with residents at admission and in resident meetings.</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>	PA Low	<p>The complaints procedure is provided to residents and family/whānau at entry to the service. A record of all complaints, both verbal and written is maintained by the manager, however a complaint register is not being maintained to evidence dates, actions taken and resolution. A review of follow-up letters demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner. Discussions with residents confirmed they were provided with information on complaints and complaints forms. The service has received two complaints in 2017. There were no complaints for 2018 (YTD). Both complaints from 2017 were reviewed with evidence of appropriate follow-up actions taken.</p>
<p>Standard 1.1.2: Consumer Rights During Service</p>	PA Low	<p>The Code is displayed in several areas of the building in English and Māori. All residents interviewed (seven – one ACC, two aged care & four MH) confirmed they received an information pack on entry that</p>

<p>Delivery</p> <p>Consumers are informed of their rights.</p>		<p>contained a copy of the Code and information about advocacy services. Staff confirmed they clarify rights and advocacy with all residents on admission and at resident's meetings. There were no posters and/or brochures displayed or accessible to residents about the Nationwide Health and Disability Advocacy Service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents interviewed stated that staff treat them with respect and dignity, and support them in their right for independence. Residents participate, to the best of their ability in daily routine tasks that promotes and endorses independence. All staff address residents by their given name or preferred name, they knock on the door before entering residents' rooms, they speak to residents in a tone, and manner that is respectful as observed during the audit.</p> <p>Staff interviewed could describe how to keep residents safe from abuse and neglect. The organisations abuse and neglect policy/procedure provides a guide on how to respond to suspected or actual abuse of residents.</p> <p>Residents said their personal privacy and the privacy of their information and belongings are respected. Residents stated that staff talk with them in a private space. Visitors and residents confirmed that they can access areas for private conversations.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The organisation has policies and procedures relating to Māori. The policies are linked with local Māori services. Māori cultural needs are identified in the information at referral. Staff interviewed stated that residents that identify as Māori have cultural needs reviewed regularly and formally as part of their care plan review. The service fosters a recovery approach and acknowledges the Treaty of Waitangi. On the day of the audit, residents interviewed, and files reviewed identified two residents that identified as Māori. Staff interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p> <p>MHA24: Current policies and procedures reflect that Māori health is a specifically identified health gain priority.</p>
<p>Standard 1.1.5: Recognition Of Pacific Values And Beliefs</p> <p>Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their</p>	<p>FA</p>	<p>The services policy and procedures support the organisations commitment to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Pacific residents are valued and fostered within the service. The policy includes links with external Pacific organisations. During this audit there were no residents who identified as Pacific, living at the facility.</p> <p>Staff interviewed were aware of the importance of the relationships between the Pacific consumer, their family and their community in the delivery of care for Pacific residents. The manager describes links with</p>

individual and cultural, values and beliefs.		Pacific representatives.
<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>Staff interviewed were aware of resident's individual needs, values and beliefs and these were noted in resident's files reviewed. Residents reported that staff were responsive to their cultural needs. They stated that they were supported to access cultural and spiritual activities important to them. Support was provided to attend spiritual gatherings. Staff explained how they acknowledge different views of spirituality as part of resident's wellbeing and personal plans.</p> <p>St Clair Park has a workforce that represents the cultural composition of the regional area and supports residents to access staff of their own culture.</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>The service has a discrimination policy and procedures that includes definitions of discrimination and is linked to the services staff Code of Conduct. The code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. The staff code of conduct is displayed in the main entrance area. Professional boundaries are defined in job descriptions. Interviews with support workers confirmed their understanding of professional boundaries including the boundaries of the support workers role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is an infringement. Residents engage socially in the community and amongst the public. This helps to break down barriers of social stigmatisation and discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service focuses on resident's strengths and their abilities and interests are at the front of the support they receive. This has a positive impact on their independence and recovery. The service has a Code of Ethics and Code of Conduct policy that is incorporated into all staff orientation. The service receives support from the district health board and includes visits from the mental health team and nurse specialist's visits. Physiotherapy and dietitian services are accessed from the district health board if required. The service has links with the local community and encourages residents to remain as independent as they are able. The GP interviewed was satisfied with the level of care that is being provided.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>Residents confirmed communication with staff was open and effective. The service has an open disclosure policy and staff interviewed confirmed their understanding of open disclosure. Any communication with family/whānau was documented in the residents' progress notes. Family interviewed (two dementia & one</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>mental health), confirmed that communication from staff was good. Where resident have family involved they were informed and this was recorded on incident forms.</p> <p>House meetings with all residents occur and there are informal daily meetings with residents. Residents have the opportunity to raise any issues/suggestions they may have and be kept informed with matters relating to the facility. Staff interviewed described working collaboratively with residents to have open and honest communication. The service has access to interpreters through the district health board.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>PA Low</p>	<p>St Clair Rest Home is privately owned. The service currently provides care for up to 41 residents at rest home (including dementia) and residential disability (psychiatric and sensory) levels of care. On the day of the audit there were 29 residents. Fourteen under a mental health contract (residential disability-psychiatric); twelve rest home residents (including three under an ARC contract, three on LTS-CHC contracts and two under 65s on ACC funding). There were three residents in the secure dementia unit under the ARC contract.</p> <p>St Clair Park had secured off a wing and opened this as a 13-bed dementia unit, at the request of the DHB. A partial provisional was clipped on to this audit to verify the 13-bed unit as suitable to provide dementia level care. The service received HealthCERT approval (letter dated 3 April 2018) to open the unit for a period of 3-months due to the urgency of beds prior to the audit.</p> <p>The service has also purchased a house next door. A resident (ACC) had moved in there two weeks before the audit as part of the resident being supported to greater independence.</p> <p>St Clair Park has a Business Quality Risk Management Plan reviewed 28 February 2018. The document includes a business plan which outlines the purpose, values, scope and direction of the organisation, and contains links to legal and contractual requirements. The quality policy statement, goals and objectives, risk management, a severity matrix and annual review of effectiveness were also included in the document. There was no evidence of evaluation of progress towards achievement of the goals. The business plan has not been updated to include adding dementia care.</p> <p>The non-clinical manager has been in the position since November 2017. She has a degree in social services and over 18 years' experience in health services, which included six years of management in 2003-2009. The manager has completed training with a local rest home, related to the management of a rest home. She is supported by a registered nurse (RN) who has been in the role since March 2018. The RN is comprehensively trained and has 6 years aged care experience (including dementia care). The previous RN left the week before the audit and the service is advertising for a second RN.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The non-clinical manager has been in the position since November 2017. She has a degree in social services and over 18 years' experience in health services, which included six years of management in 2003-2009. The registered nurse would perform the manager's role in her absence.</p> <p>The RN has over 6 years' experience in aged care including dementia. The service is in the process for advertising for an RN to support the current RN.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>MHA24: St Clair Park has a Business Quality Risk Management Plan developed February 2018, which meets contractual requirements. There has been no review of progress against quality goals (link 1.2.1.1). St Clair Park has a smoke free policy that meets contractual requirements (link 1.2.7.5). The service has a child protection policy and procedure that meets contractual requirements. Staff have had training around abuse and neglect in the last two years. The nurse practitioner for the local DHB is in daily contact with the service and provides supervision to the RN.</p> <p>MHA24: A document control system is in place. Policies have been regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures relate to the different types of service provided and have been updated to meet current health and safety legislation and interRAI requirements.</p> <p>The RN completes a monthly report that includes the monthly monitoring, collation and evaluation of infection control and incident data. This report is discussed at staff meetings. An annual internal audit schedule was sighted for the service, but not all internal audits had occurred as per the audit schedule. Corrective actions are always documented when service shortfalls are identified, but there is no sign off when these are completed.</p> <p>The service holds a monthly staff meeting (the RN report was sighted but the June meeting minutes could not be located). The RN and the manager meet monthly and discuss infection control, but these meetings are not minuted.</p> <p>A family survey was sent out prior to the audit and there had been no survey forms returned at the time of the audit. There was no evidence of previous resident or family surveys.</p> <p>Falls prevention strategies are in place. The manager is the health and safety representative. A health and safety system is in place. Hazard identification forms and a current hazard register are in place. Staff have not received health and safety training since 10 March 2017. There is no documented discussion of health</p>

		and safety in staff meetings.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the quality and risk management programme and individual incidents are discussed in combined quality/staff meetings (link 1.2.3.6). Thirteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Where corrective action plans were created there was no evidence of these being signed off (link 1.2.3.8).</p> <p>The manager is aware of their requirement to notify relevant authorities in relation to essential notifications. The manager reported that the coroner is investigating the sudden death of a resident and public health were notified of an outbreak of vomiting and diarrhoea since the previous audit.</p>
<p>Standard 1.2.5: Consumer Participation</p> <p>Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.</p>	PA Low	<p>St Clair has a residents meeting, which allows residents to have input into the service, however this is not minuted (link 1.2.3.6). The manager operates an open-door policy. Resident and staff interviewed stated that residents feel confident talking to staff and management about services. A resident and a relative satisfaction survey has been implemented with a positive result from residents. The relative survey has recently been sent out and the service is waiting for responses. The manager advised there are regular meetings with residents, but meeting minutes are not documented. Resident do not have input at all levels of service delivery.</p>
<p>Standard 1.2.6: Family/Whānau Participation</p> <p>Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.</p>	PA Low	<p>St Clair Park has a family participation policy that includes terms of reference for families who choose to be involved in an advisory capacity. Relatives are also invited to complete an annual satisfaction survey and there is regular contact from the service to families around resident updates. In practice, most relatives do not have close involvement with the resident or the service. The family participation processes described in policy are not implemented.</p>
<p>Standard 1.2.7: Human Resource Management</p>	PA Moderate	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Six staff files sampled (the manager, registered nurse, the activities coordinator and three support workers) included evidence of employment contracts. All had current job descriptions and</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>evidence of reference checks. Three staff were new and the other three did not have a current appraisal. The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Documentation in staff files did not evidence all staff completing a documented orientation. Staff interviewed, including new staff, stated that new staff are adequately orientated to the service. The manager is in the process of updating the orientation.</p> <p>A register of practising certificates is maintained. The part-time registered nurse (currently working full time due to the nurse vacancy) has six years aged care experience and is a comprehensive trained nurse.</p> <p>There is an annual education and training schedule, but not all required training has been completed in the past two years. Two support workers have completed the level four mental health support certificate. A further three staff have completed the National Certificate in Health, Disability and Aged Support (core competencies level 3) national certificate in Health, Disability and Aged Support (core competencies level 3). The manager has enrolled the other support workers to complete training.</p> <p>MHA24: The RN has not had smoking cessation training. The staff team includes people who have level 3 & 4 Careerforce qualification and are trained (or in the process of training) to provide community based recovery focused support services to people.</p> <p>The registered nurse is in the process of completing the interRAI training and competency. There is currently no interRAI trained RN at the facility.</p> <p>Partial provisional: There is one support worker who has completed the Careerforce dementia standards. The facility is engaging in Careerforce training. The manager is discussing with Careerforce, a training plan to support staff to complete required dementia training. Staff had completed management of challenging behaviours, and recognising triggers and de-escalation.</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>PA Low</p>	<p>There is a staffing policy. The registered nurse is comprehensive trained, but has never worked in mental health and is not experienced for the role. The RN is currently working full-time Monday to Friday until the RN vacancy is filled and is on-call 24/7 (MHA24). The nurse practitioner for the local DHB is in daily contact with the service and provides supervision to the RN. The residents under a mental health contract do not have an identified support worker as their key worker (MHA24).</p> <p>The service is divided into three units. At the time of the audit Cargill (dementia unit) housed three residents. This unit has one support worker on every shift.</p> <p>In Ashwood unit, there are nineteen residents, five residents under the aged care contract, twelve under the MHA24 contract, and two under the long-term support chronic health conditions contract. This unit has two support workers am shift one x 6.45 am - 3.15 pm, one x 8.00 am – 1.00 pm; two x support workers pm shift one x 3.00 pm – 11.00 pm, one x 5.00 pm – 9.00 pm. One x night shift 11.00 pm – 7.00 am – shared across</p>

		<p>Middleton unit.</p> <p>In Middleton unit, there are seven residents, one under ACC, two under aged care contract, and three under MHA24 contract. The other ACC resident has moved to a house next door and is seen by staff hourly during the day. One x support worker am shift and pm shift.</p> <p>The activities coordinator works in the activities role 32-hours per week and works the other eight hours as a support worker. There is a cleaner employed.</p> <p>Interviews with the residents, family (whānau) and staff confirmed staffing meets residents' needs.</p> <p>Partial Provisional: There was no draft roster available for the proposed dementia unit. The unit is currently staffed with one support worker 24/7 with registered nurse oversight. There is no recruitment plan for the new unit.</p>
<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 residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.</p> <p>Residents' files demonstrate service integration. Entries sighted were legible, timed, dated and signed by the relevant support worker or nurse but did not always include designation (link 1.3.3.4).</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>Rest home and Dementia level: The service has admission policies and procedures in place to support admission. Residents are assessed prior to admission by the needs assessment team. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The manager and clinical leader (registered nurse) screen all potential residents prior to entry and records all admission enquiries. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. However, not all files reviewed contain a signed admission agreement (link 1.1.10.2).</p> <p>Mental Health: Access processes and entry criteria are outlined in policy. All referrals are made by the mental health service and discussed on an individual basis by the DHB nurse practitioner assigned to St Clair Park, with the manager and the nurse to ascertain suitability. Residents come for an initial visit where possible, usually with family and the case manager. All potential residents have a needs assessment completed by the service coordination service prior to referral.</p> <p>Each new or prospective resident is given an information pack that is part of the admission agreement. The</p>

		<p>resident information includes information around the Code of Rights, health and disability advocates, information on how to make a complaint and consent form.</p> <p>However, not all files reviewed contain a signed admission agreement for rest home or mental health (link 1.1.10.2).</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>All care levels: There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the receiving provider using the yellow envelope system. Transfer forms sighted were completed, with good documentation of liaison between GP and DHB on transfer to and from the hospital. Family interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</p> <p>MHA24: There have been no planned discharges since the previous audit, as appropriate for the client group.</p> <p>The discharge planning form includes the following:</p> <ol style="list-style-type: none"> 1. Involvement of residents and with their consent, this is communicated to all relevant support people. 2. Reassessment of risk, the relapse prevention plan and follow-up arrangements. 3. Advance directives. 4. Identifies medication on discharge and education about this. 5. Identification of relevant cultural needs. 6. Reference to psychosocial support needs. 7. Reference to: a) support needs, b) pre-vocational, and c) educational needs. <p>The service policies document a planned exit, discharge or transfer of residents that is documented, communicated and effectively implemented. A discharge summary would be given to the resident and where relevant, the general practitioner/primary care provider and support people.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and</p>	FA	<p>Fourteen medication charts were reviewed. The medication management policies and procedures comply with medication legislation and guidelines. An electronic medication system is in place. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication competent registered nurse and support workers administer medicines. The facility uses a blister pack</p>

<p>timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>medication management system for the packaging of all tablets. The registered nurse reconciles the delivery and documents this. There was evidence of three-monthly reviews by the GP. Medications are prescribed and charted in line with guidelines. 'As required' medications have been correctly prescribed indicating reason for administration. There are no residents who self-administer medications.</p> <p>Partial provisional: The staff working in the dementia unit are medication competent. There is a locked medication room, with a locked medication trolley and safe storage of medications in the medication trolley.</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 Low</p>	<p>All service levels: All food is prepared and cooked off-site by an external contractor and delivered in hot boxes at meal times. It is then transferred into bain maries and temperature checked before being served by support workers. A dietitian reviews all menus for the contracted food services company. Staff have completed basic nutrition and food safety training as sighted in training records. Special diets and likes and dislikes are catered to as reported by staff and residents interviewed. Changes suggested/requested by residents are faxed to the kitchen and the menu altered accordingly. Meals are appropriate to the client group, with individual meals supplied that cater to likes and dislikes and nutritional requirements. Breakfast is served as residents are ready for it. There is a wide variety of fresh fruit and snacks available for residents. Morning and afternoon teas are delivered with the main meals. Fridge and freezer temperatures are monitored in the dementia unit, but not available in the other two units. The records were sighted, and temperatures were noted to be within safe ranges in the dementia unit. Food and meals are discussed at resident meetings. Residents and relatives interviewed were complimentary of the meals provided.</p> <p>Partial provisional: There is an existing kitchen servery in one end of the spacious dining room in the dementia unit. There is a locked cupboard available. The owner of the food services company was interviewed, and reported the company works very closely with the facility to provide food that is suitable for resident needs and can cater for all types of diet. Snacks are available 24 hours in the dementia unit.</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>	<p>FA</p>	<p>Rest home and Dementia level: The service records the reason for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. This is stated in the agreement.</p> <p>Mental health: Residents have not been declined unless there is a lack of suitable placements, although residents may decide not to come to the service after the initial tour. They are then referred back to the needs assessment service. All declined entries are discussed with referrers.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All care levels: The facility has embedded the interRAI assessment protocols within its current documentation. The newly appointed RN is training in the use of interRAI (link 1.2.7.3). All residents have interRAI assessments completed. InterRAI initial assessments and assessment summaries were evident in printed format in the files reviewed. Files reviewed identified that risk assessments had been completed on admission and had been updated at the time of the care plan review. Mental health residents also have a mental health support assessment. Care plans reflect assessments. Strengths assessments have been completed for all residents with goals and a plan developed. These have been reviewed three monthly. Cultural assessments are completed for mental health residents and link to care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>All care levels: Care plans reviewed were overall personalised and demonstrated service integration and input from allied health. However, not all care plans included specific interventions for all identified care needs. Care plan documentation sampled, reflected acute changes in health status. Support plans included crisis plans containing identification of early warning signs, relapse prevention and crisis intervention plans. Family members interviewed confirmed they are very satisfied with the care delivery and support by staff. Registered nurses and support workers interviewed can describe interventions required and are knowledgeable around all aspects of all resident support needs.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Rest home and Dementia: Support workers follow the care plan and report progress against the care plan at the end of each shift. The care and support observed was seen to be respectful. Residents and relatives interviewed were happy with the support provided to them. If external nursing or allied health advice is required, the registered nurse will initiate a referral (eg, to the physiotherapist or dietitian). If external medical advice is required, this will be actioned by the GP. The nurse practitioner for mental health works closely with the registered nurse and liaises regularly with the GP. EPOA's have been activated for two of three residents residing in the dementia unit, one resident is waiting on a welfare guardian to be appointed.</p> <p>Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are also available. Specialist continence advice is available as needed and this could be described.</p> <p>Resident's weight is monitored regularly, there were no residents with unintentional weight loss on the day of the audit. Monitoring forms sighted include (but not limited to); behaviour, falls, bowels, daily living activities, weight and vital signs.</p> <p>There were no pressure injuries or wounds on the day of audit. Wound documentation sighted for previous wounds includes assessments, management plans, progress and evaluations. The RN has access to specialist nursing wound care management advice through the district nursing service.</p> <p>MHA24: The recovery/support plans reviewed identified the support staff involved in the resident's care, but</p>

		<p>did not include a key support worker (link 1.2.8.1), mental health case manager and psychiatrist. Assistance and support is sought for matters relating to personal, clinical, cultural, spiritual and social domains. All residents at St Clair Park have diagnoses of mental health conditions and all receive services that promote independence, are supportive and tailored to their individual needs.</p> <p>MHA24: Planned and time-limited support services/responses, based upon regular support needs assessment that informs a recovery/support plan are designed to meet the person's individual needs. This then reduces their need to utilise more intensive mental health services. The support services available are inclusive of the person's cultural needs and contribute to meaningful, positive changes in the resident's life.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>All service levels: The recently appointed activities coordinator works 28 hours a week in activities and is working towards a qualification in diversional therapy. The programme is planned weekly. Individualised activity assessments and activity plans are completed (link 1.3.8.2). Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. The service receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families. The residents and families interviewed spoke positively about the activities programme. The programme includes outings in the car, church services, and arts and crafts, happy hour and entertainers that visit the facility. There are resources available for staff to use for one-on-one time with the residents and for group activities. Residents are supported to engage in activities of their choice in the community, these include the octagon club, art centre, pottery classes, and going out for meals. Residents commented positively on activities provided.</p> <p>MHA24: Staff encourage and support residents who are able with shopping, personal laundry and tidying their bedrooms and communal areas. Residents are supported at different levels of ability to attend community activities, social networks such as community family/whānau groups, church services, other services and arts and crafts.</p> <p>Partial provisional: The service currently employs an activities coordinator. There is a bookshelf in the lounge in the dementia unit where a variety of games are currently stored, support workers have access to these when the activities coordinator is not present. Support workers provide impromptu activities to engage residents and support other behaviour management techniques. The activities coordinator will develop the programme and provide support to support workers as knowledge increases. Residents residing in the dementia unit were observed enjoying afternoon tea in the enclosed garden and participating in work games and jigsaws. Current residents are encouraged to go on outings. The activities coordinator has completed some online training around dementia.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>All care levels: In all files sampled, the written evaluations were completed at least six monthly. The GP reviews each resident at least three monthly and more frequently for residents with more complex problems. Changes in health status are documented by support workers and reported to the registered nurse (link 1.3.3.4). Not all care plan evaluations reflect progression towards resident goals. Activities assessments and plans are in place, but are not always reviewed in a timely manner. Short-term care plans sighted had been evaluated and signed off as resolved. Where progress is different from expected, the service responds by initiating changes to the care plan. Staff stated that family members are informed of any changes to the care plan and this was evidenced in the family correspondence forms and in interviews with family members.</p> <p>MHA24: There is a process of formally reviewing recovery plans, goals and outcomes both with the resident and in a multidisciplinary setting. The review includes the resident and with their consent, their family/whānau.</p> <p>MHA24: The recovery/support plan sets out specific plans and goals that are reviewed three-monthly with a formal reviewing at least six-monthly. In accordance with their plan, people using the service aim to progress towards more independent living, or, as mutually agreed, will maintain their level of independence by developing skills and supports. The service recently bought the house next door and a resident had moved in two weeks before the audit as part of increasing their independence.</p>
<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>	<p>FA</p>	<p>Discussions with the registered nurse identified that the service has access to external and specialist providers. There are close links with mental health services. Referral documentation is maintained on resident files. The registered nurse initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. The service was able to describe the process they would use if the residents' needs changed and the resident required a different level of care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and</p>	<p>FA</p>	<p>A documented waste management procedure directs staff in how to dispose of household and infectious waste. The service has an equipped spills bucket. Cleaning agents, solvents, powders and fluids are stored in a locked cupboard. No flammable liquids are kept on-site. Protective equipment such as gloves and masks are available on-site.</p>

<p>service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>Partial provisional: The current processes around the management of waste and hazardous substances has continued in the dementia unit. There are locked cupboards available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Moderate</p>	<p>The service is divided into three units; two units for aged care and mental health residents that are linked by corridors and a secure dementia unit.</p> <p>Corridors allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade.</p> <p>Staff stated they have all the equipment required to provide the level of care documented in the care plans. The building has a current building warrant of fitness that expires on 6 July 2019. There is a maintenance staff member available on call for facility matters. Planned and reactive maintenance systems are in place. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. The service hot water is provided through gas cylinders. Staff stated it has been set at a safe level for residents. Hot water temperatures have not been tested or recorded.</p> <p>MHA24: The service has a comprehensive smoke free policy that applies to all staff, residents, family/whānau, visitors, facilities and vehicles. The policy complies with the smoke free environments Act and its amendments, the health and safety in employment Act 1992 and its amendments. The smoke free policy has not been implemented within the service. There are designated smoking areas on the premises. Not all registered health professionals employed by the service have completed smoking cessation training (link 1.2.7.5).</p> <p>Partial provisional: The dementia unit is an existing wing of the facility. The internal door from the foyer into the unit has a secure keypad entry. The current dining room is light and spacious enough for the proposed 13 residents (12 long-term and one respite). There is an existing kitchen servery at one end. Adjacent to the dining room is a small lounge area with external sliding door, which is large enough for the current resident needs. There is room for residents to wander in the unit. There is an existing fire exit door mid-way down the corridor which releases in the event of a fire into the carpark. The current external garden area is fully fenced and secure and easily accessible. The fence has been adjusted to ensure the area is secure. There is an outside seating and shaded area.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing</p>	<p>FA</p>	<p>There are adequate numbers of accessible toilets/showering and bathing facilities. Visitors toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided</p>

<p>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>		<p>in the toilet/shower/bathing areas and other equipment/accessories are made available to promote client independence. Residents and family members reported there are sufficient toilets and showers.</p> <p>Bathroom facilities sighted in both sites are appropriate for use, clean and private. There are separate toilet facilities for staff and visitors use.</p> <p>Partial provisional: Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are communal use bathrooms/toilets in the dementia unit. There are communal toilets located near the lounge/dining rooms. Communal toilet facilities have a system that indicates if it is engaged or vacant.</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>There is adequate personal space provided in bedrooms which allows residents and staff to move around within the room safely. Residents interviewed spoke positively about their rooms. Mobility equipment was sighted in rooms of residents requiring this, with sufficient space for both the equipment, staff and the resident. Resident rooms were observed to be private, single and shared bathroom and toilet facilities, appropriate to the group. There is adequate room to safely manoeuvre mobility aids in the resident bedrooms.</p> <p>Partial provisional: All resident rooms in the dementia unit are homely and suitable to meet the needs of residents with dementia. There is adequate personal space provided in bedrooms which allows residents and staff to move around within the room safely. Rooms are and can be personalised with furnishings, photos and other personal adornments. Resident rooms are all single.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas within the facility include open plan lounge and dining area in each unit. There are smaller lounges and a family room within the facility. The communal areas are easily accessible for residents.</p> <p>Seating and space is arranged to allow both individual and group activities to occur.</p> <p>Partial Provisional: The communal area comprises of a large dining room area and a small lounge. However, the dining area has other sitting areas. There is also a small lounge area at the other end of the unit currently used for family visits, but rarely utilised by current residents. The manager is planning to review and improve the current lounge lay-outs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with</p>	FA	<p>There are policies and procedures that provide guidelines regarding the safe and efficient use of laundry services. There is a dedicated housekeeping staff member. The cleaning chemicals are kept in designated locked cupboards. Laundry is completed by staff or by residents with staff support where able. There is</p>

<p>safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>one small laundry for domestic use and a larger laundry (off the dementia unit) with a commercial washer and dryer. Residents interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.</p> <p>Partial Provisional: The main laundry (while small) is off the dementia unit and is always locked. There is a dirty to clean flow. There is an external door, so staff can deliver linen to the laundry without going through the unit. Cleaning staff only take what chemicals and cleaning supplies are required for each resident room so there are no chemicals or cleaning solutions unattended at any time. PPE is available throughout the unit. The sluice room is housed within the laundry area. Chemical training has been provided and there are datasheets visible in the laundry/sluice area. All chemicals are in original containers with a closed system for laundry and cleaning needs.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Moderate</p>	<p>Emergency and disaster policies and procedures are in place. An approved fire evacuation plan is available. Fire equipment was tested in July 2018. The orientation programme and education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. A fire evacuation drill occurred in June 2018.</p> <p>A civil defence plan is in place. Power is available in the facility for up to two hours following a power outage.</p> <p>A call bell system is in use. Only the activities coordinator has first aid training (link 1.2.7.5).</p> <p>External lighting and security systems are adequate for safety and security.</p> <p>MHA24: The service has a current emergency management plan and includes a pandemic plan. The plan is consistent with the DHBs pandemic and emergency plans. A copy is available to the DHB on request. The service will be involved in processes to ensure that emergency responses are integrated, coordinated and exercised when requested by the DHB. However, staff and management interviewed, confirmed there are no supplies in the event of a civil defence emergency.</p> <p>Partial provisional: Advised here are no required changes to the evacuation plan as the footprint or placement of rooms and the lounge is not changing. The fire service has reviewed the unit with no required changes to the evacuation scheme. There is call bells throughout the unit.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe</p>	<p>FA</p>	<p>Residents rooms have at least one external opening window of normal proportions and plenty of natural light. The home has heat pumps and additional heaters if required. The home was warm and comfortable on the day of the audit.</p> <p>Partial provisional: The communal areas are light and airy, with external windows with views of the garden.</p>

<p>ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>All resident rooms have external windows. Resident rooms have individual heaters. The unit maintains a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>St Clair Park have a suite policies and procedures in place which reflect best practice. Surveillance reports are collated and analysed on a monthly basis and there is a monthly report written. Last year's statistics have been reviewed and a report has been completed. The programme has been reviewed annually. The previous infection control nurse has recently resigned, and the new registered nurse is orientating to the role. Infection control is discussed at meetings and there are monthly discussions with the registered nurse and the manager. The facility has access to the DHB infection control specialist for advice. There was a small outbreak in May 2018, and correct procedures were followed, advice was sought and notification was made.</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>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and manager have external support from the local laboratory infection control team and IC nurse specialist at the DHB. There are adequate hand gels and hand washing facilities available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical,</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, and training and education of staff. The policies are reviewed and updated at least annually.</p>

safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has not occurred in line with policy (link 1.2.7.5). The infection control nurse has completed some infection control training at the DHB and reported learnings at the last staff meeting. Online education is available to staff. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Systems in place are appropriate for the size and complexity of the facility. Infection surveillance is an integral part of the infection control programme and is described in St Clair Parks infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff meetings. There has been one outbreak since the previous audit. There have been no infection control internal audits completed in the last year (link 1.2.3.6).</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>St Clair Park maintains a restraint-free environment. The service has documented systems in place to ensure the use of restraint is actively minimised. There were no enablers in use. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Enablers are voluntary. Staff have not completed training on restraint or enablers (link 1.2.7.5).</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.	PA Low	Residents and families are provided with relevant information to be actively involved in the resident care. Consent forms sighted are signed appropriately, and staff interviews confirmed residents are provided with choice in their cares. However, do all files reviewed included a signed consent form. Advance directives and CPR forms are appropriately signed and are current. Not all residents have signed admission agreements on file. The dementia files reviewed included an activated EPOA.	(i) Four of seven resident files reviewed (one dementia level, one LTS-CHC, one ACC, and one mental health) did not have a signed consent form. (ii) Five out of seven files did not have signed admission agreements on file (two mental health, one ACC, one LTS-CHC, one dementia) and the dementia resident is waiting on welfare guardianship to be appointed.	Ensure all residents have a signed general consent form and admission agreement on file. 60 days
Criterion 1.1.13.3	PA Low	The organisation supports residents to make complaints. Complaint procedures are included and discussed with residents	The service does not have a	Ensure there is a current,

<p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>		<p>on entry through the resident's information pack. The complaints process is fair, documented and complies with Right 10 of the Code. The service does not have a complaints' register.</p>	<p>complaints' register.</p>	<p>maintained complaints register that includes all complaints, dates, and actions taken.</p> <p>90 days</p>
<p>Criterion 1.1.2.4 Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.</p>	<p>PA Low</p>	<p>The resident's information pack contains information regarding advocacy services and is brought to the attention of the residents at admission and resident meeting. There were no posters and/or brochures displayed or accessible to residents about the Nationwide Health and Disability Advocacy Service.</p>	<p>There were no posters and/or brochures displayed or accessible to residents about the Nationwide Health and Disability Advocacy Service.</p>	<p>Ensure information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible for residents.</p> <p>90 days</p>
<p>Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	<p>PA Low</p>	<p>St Clair Park has a Business Quality Risk Management Plan reviewed 28 February 2018. The document includes a business plan which outlines the purpose, values, scope and direction of the organisation, and links to legal and contractual requirements.</p>	<p>(i)There is no evidence of any evaluation of progress towards the goals in the Business Quality Risk Management Plan. (ii) The business plan has not been updated to include adding dementia care</p>	<p>Ensure the Business Quality Risk Management Plan is regularly reviewed to evaluate progress. (ii) Ensure the Business Quality Risk</p>

				management plan is updated to include adding dementia care services. 90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality data is reported through the monthly RN report. This report is tabled and discussed with the meetings. There is a monthly staff meeting (minutes sighted for 2018, but could be located for 2017. Staff meeting minutes reviewed did not routinely evidence feedback/discussion on H&S and infection control. Resident meetings are not minuted (link 1.2.5.1)	Staff meeting minutes reviewed did not routinely evidence feedback/discussion on H&S and infection control.	Ensure staff meetings continue to be held regularly and reflect discussion of quality data including (but not limited to) H&S and infection control 180 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	An annual internal audit schedule was sighted for the service, but not all internal audits had occurred as per the audit schedule. Corrective actions are documented when service shortfalls are identified, and the manager was able to discuss her follow-up to these, but there is no sign off when these are completed.	i) Auditing had not occurred as per the schedule and in 2018 (YTD), there has been no infection control, recreation, care plan, or resident meal satisfaction audits. ii) Corrective actions are documented when service shortfalls are identified, but there is no sign-off when these are completed.	i) Ensure all audits occur as per the schedule. ii) Ensure all identified corrective actions are signed off as complete. 90 days

<p>Criterion 1.2.5.1</p> <p>The service demonstrates consumer participation in the planning, implementation, monitoring, and evaluation of service delivery.</p>	<p>PA Low</p>	<p>There was no specific consumer/resident/client participation policy. Residents' feedback verbally to staff and management. The manager advised there are regular meetings with residents, but meeting minutes are not documented. Resident's interviewed said they met sometimes with the manager. A resident satisfaction survey has recently been completed. There were 18 responses from 29 surveys of residents in July 2018, but they had not been collated at the time of the audit. The service does not have a consumer advisor or representative. Staff did not identify as having lived experience from a consumer's perspective. The service does not demonstrate that residents participate at all levels of service delivery.</p>	<p>Residents do not have input at all levels of service delivery.</p>	<p>Ensure residents have participation in planning, implementation, and monitoring of service delivery.</p> <p>180 days</p>
<p>Criterion 1.2.6.1</p> <p>The service demonstrates family/whānau and community participation where relevant, in the planning, implementation, monitoring, and evaluation of service delivery.</p>	<p>PA Low</p>	<p>The service actively contacts families regarding the residents, and families are invited to complete the annual relatives' survey. A satisfaction survey was sent out to 26 whanau/family a few days prior to the audit (July). There is a comprehensive policy outlining the processes to engage families at all levels of the service. In practice, most families do not have close involvement with the resident or the service and the policy is not implemented.</p>	<p>The processes described in policy to involve family in all levels of the service are not implemented.</p>	<p>Ensure a family perspective is provided in the planning, implementation, monitoring and evaluation of service delivery.</p> <p>180 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Low</p>	<p>The registered nurse is in the process of completing the interRAI training and competency. The MH nurse practitioner is also completing training in interRAI using St Clair resident's files for training. There are 19 support workers with a variety of mental health support and aged care certificates. The manager has enrolled the other support workers to complete training. The manager advised there are sufficient staff to cover the dementia unit without employing more staff. However, there is plans to employ as numbers increase. There is one support worker who</p>	<p>The registered nurse is in the process of completing the interRAI training and competency. There is currently no interRAI trained RN at the facility</p>	<p>Ensure there is access to a trained interRAI assessor</p> <p>60 days</p>

		has completed the Careerforce dementia standards.		
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA</p> <p>Moderate</p>	<p>The service has a documented orientation programme which the new manager is in the process of updating. Staff reported that new support workers receive a comprehensive orientation that can be extended if required. Two of six staff files reviewed contained documentation of a completed orientation.</p>	<p>Four of six staff files reviewed did not include evidence the staff member completed an orientation.</p>	<p>Ensure there is documented evidence that all new staff complete an appropriate orientation.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>Staff training was provided monthly in 2017, with staff attendance at training recorded. Regular training has not been provided in 2018 – staff have received medication training and completed medication competencies, also chemical and food safety training. Staff had completed management of challenging behaviours, recognising triggers and de-escalation, pain identification and management, promoting continence and managing incontinence. Staff have not all completed the required areas as per schedule. Three staff were new and the other three did not have a current performance appraisal.</p>	<p>(i) Staff training has not been provided around: resident's rights, health and safety and infection control. (ii) Only one staff member has a current first aid certificate (training is booked for the 8 and 14 August). (iii) The RN has not completed smoking cessation training. (iv) Three of six staff files reviewed did not contain a current performance appraisal.</p>	<p>(i)-(iii) Ensure all staff receive all required training. (iv) Ensure all staff who require an appraisal have this completed annually.</p> <p>60 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order</p>	<p>PA</p> <p>Low</p>	<p>The registered nurse is comprehensive trained, but has never worked in mental health and is not experienced for the role. The RN is currently working full-time Monday to Friday until the RN vacancy is filled and is on-call 24/7 (MHA24). The nurse practitioner for the local DHB is in daily contact with the service and provides supervision to the RN. The residents under a mental health contract do not have an identified support worker as their key worker (MHA24).</p>	<p>MHA24: The residents under a mental health contract do not have an identified support worker as their key worker.</p> <p>Partial Provisional: There is no recruitment plan or draft roster for the dementia unit.</p>	<p>Ensure all residents under a mental health contract have an identified key worker as per contractual requirements.</p>

to provide safe service delivery.		Partial Provisional: There was no draft roster available for the proposed dementia unit. The unit is currently staffed with one support worker 24/7 with registered nurse oversight		Partial Provisional: Complete a recruitment plan and draft roster. 90 days
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	Nutritional needs are accommodated for all residents. Temperatures are checked, and procedure is followed if food temperatures are not within recommended ranges. Fridge and freezer temperatures are monitored in the dementia unit, but there was no evidence of temperature checks in the other two units.	There were no fridge or freezer temperatures available on the day of the audit for two units.	Ensure all temperatures for food, fridge and freezers are checked as per policy. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	Progress notes are written at the end of each shift by support workers, however not always in line with policy. Registered nurse follow-up is not always documented in the progress notes. Registered nurses document in progress notes when there is a change in condition. Relatives are invited to attend GP reviews. The family contact sheet form in the file demonstrates relatives are informed of changes and updated following GP reviews. Family visits are also documented on this form. Staff interviewed described a verbal handover at the end of each duty. The service contracts physiotherapy services as required	(i)There was no documented registered nurse follow-up in two of four files reviewed (one LTS-CHC, one rest home) where support workers had identified infections and incidents. (ii) Ensure all progress notes are signed with a signature and designation.	(i)Ensure registered nurse follow-up is documented in the progress notes. (ii) Ensure all progress notes are signed with a signature and designation 90 days
Criterion 1.3.5.2 Service delivery	PA Low	There is a new initiative in place to replace the current momentum care plans, with new lifestyle support plans to allow for clearer individual care plans for each need identified in the	Four of seven (one LTS-CHC, two rest home, one dementia) files reviewed did not include	(i)-(iv)Ensure all care plans include

<p>plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>assessment process instead of the current system. This is in the early stages of development. New residents admitted to the facility have this in place, three out of four files reviewed had the momentum care plan still in place.</p>	<p>interventions to support all identified needs.</p> <p>(i) One rest home resident (on LTS-CHC) did not have interventions documented in the short-term care plan to address the urine infection.</p> <p>(ii) One rest home resident had no specific individualised de-escalation techniques.</p> <p>(iii) One rest home resident (tracer) had no nursing interventions around recurrent cellulitis and recently diagnosed heart failure.</p> <p>(iv) The dementia resident reviewed included lack of detail around falls prevention.</p>	<p>individualised interventions to support all identified needs.</p> <p>60 days</p>
<p>Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Low</p>	<p>Initial care plans were evaluated and used to create the long-term care plan within expected timeframes. InterRAI and long-term care plans have been reviewed at least six monthly (link 1.2.7.3). Not all care plans reflect progression towards resident goals. Activities assessments and plans are in place, but are not always reviewed in a timely manner.</p>	<p>i) Evaluations in the momentum care plans continue not to show degree of progression towards resident goals.</p> <p>ii) Activities plans are not evaluated in a timely manner in all seven files reviewed.</p>	<p>i) Ensure all care plans are reviewed in a timely manner and show progression towards goals.</p> <p>ii) Ensure all activities plans are evaluated.</p> <p>60 days</p>
<p>Criterion 1.4.2.1</p>	<p>PA</p>	<p>There is an existing locked fire door mid-way down the corridor</p>	<p>Hot water temperatures have</p>	<p>Ensure hot</p>

All buildings, plant, and equipment comply with legislation.	Moderate	of the secure unit, the lock releases in the event of a fire into the care park. Advised this would be monitored closely by staff in the event of a fire. The service hot water is provided through gas cylinders. Staff stated it has been set at a safe level for residents. Hot water temperatures have not been tested ay resident areas or recorded.	not been tested and to evidence they comply with current legislation.	water temperatures are taken regularly and recorded and monitored. 30 days
Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	MHA24: The service has a comprehensive smoke free policy that applies to all staff, residents, family/whānau, visitors, facilities and vehicles. The policy complies with the smoke free environments Act and its amendments, the health and safety in employment Act 1992 and its amendments.	The smoke free policy has not been implemented within the service. There are designated smoking areas on the premises.	Ensure the services smoke free policy is implemented. 180 days
Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.	PA Moderate	Power is available in the facility for up to two hours following a power outage. Staff and management interviewed confirmed there are no supplies in the event of a civil defence emergency. Extra blankets are available. There are snacks available but not enough extra food to meet civil defence requirements.	The service has no food or water supplies in the event of a civil defence emergency.	Ensure the service has supplies of food and water as per civil defence guidelines. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.