

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

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	St Clair Park Residential Centre Limited
<b>Premises audited:</b>	St Clair Park Residential Centre
<b>Services audited:</b>	Rest home care (excluding dementia care); Residential disability services - Psychiatric
<b>Dates of audit:</b>	Start date: 28 March 2019 End date: 29 March 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	33



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

St Clair Residential Park is privately owned. The service is certified to provide rest home, dementia and residential disability (psychiatric) level care for up to 39 residents. On the day of the audit there were 33 residents.

This unannounced surveillance audit was conducted against a subset of 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, staff and management.

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 an assistant manager and two registered nurses (RN). Feedback from residents and families was positive about the care and services provided.

The service has been working through their previous audit shortfalls. They have support by a nurse consultant. Processes and systems are being reviewed. Further systems are being developing and established. A number of improvements have been noted since last audit which include environmental improvements and establishing processes to cover the specific needs of the residents in the three different wings.

Twelve of the nineteen shortfalls from the previous audit have been addressed. These were around advocacy information, complaints register, business plan, corrective actions, staff training, staffing, progress notes, interventions, evaluations, temperature monitoring, hot water, and smoke-free policy.

Further improvements continue to be required around consent, orientation, staff files, quality system, resident and family participation, and civil defence supplies.

This audit has also identified improvements required around hazard management, adverse event management, mental health goals, mental health client files, medication management and food safety.

## 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 medium or high risk and/or unattained and of low risk.
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There is information available for residents around advocacy services and the complaints processes. Interviews with residents demonstrated they were provided with adequate information and that communication is open. Open disclosure is practiced and appropriate communication with residents and families/whānau is implemented. There are documented informed consent processes. There is a complaints register and complaints are managed.

## 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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There is a business and quality plan that has been reviewed for 2019. The manager, assistant manager and RNs are responsible for the day-to-day operations of the facility. The manager provides a weekly report to the director which includes feedback on quality. There are regular resident meetings and staff/management meetings. There are human resources policies in place, including recruitment, selection, orientation and staff training and development. There is a documented training plan that is being implemented. A staffing roster is implemented across the three areas.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurse is responsible for 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

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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St Clair Park has a current building warrant of fitness. Procedures are in place for emergencies, Maintenance systems are in place. The building is appropriately heated and ventilated. All bathroom, personal space areas, outside and communal areas are suitable for resident needs. There are processes in place to ensure a safe environment for residents, staff and visitors that are appropriate to the service delivery setting.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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St Clair Park has a restraint-free environment 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.
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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. 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)
<b>Standards</b>	0	12	0	6	5	0	0
<b>Criteria</b>	0	49	0	7	6	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.10: 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>	<p>PA Moderate</p>	<p>Current advance directives and CPR decisions are on all resident files. Medically initiated not for resuscitation forms are completed by the general practitioner (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 and registered nurse (RN). Resuscitation forms are reviewed annually. Consent forms sighted are signed by the resident or Enduring Power of Attorney (EPOA). Relatives interviewed felt they were well informed of changes in resident condition.</p> <p>The previous finding has been partially met. All residents have a signed admission agreement and general consent form on file, however, not all residents have in the dementia unit have activated EPOAs on file.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	<p>FA</p>	<p>The complaints procedure is provided to residents and family/whānau at entry to the service. Complaint forms are available around the facility. A record of all complaints, both verbal and written is maintained by the manager. A complaint register has been introduced since previous audit which includes 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 six written complaints since previous</p>

<p>understood, respected, and upheld.</p>		<p>audit to (YTD). Five of the complaints were from staff and managed effectively through the HR process. One complaint from an external stakeholder has been managed with evidence of follow up corrective actions including abuse and neglect training for staff and effective communication for staff. Complaints are discussed at staff meetings. The manager has been proactive in addressing the issues arising from complaints and ensuring staff learn from them.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed (three rest home and two mental health) confirmed they have received information on the Code and advocacy services. Staff confirmed they clarify rights and advocacy with all residents on admission and at resident's meetings. There are posters and brochures accessible to residents about the Nationwide Health and Disability Advocacy Service. This is an improvement on previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Six residents interviewed (four rest home, two mental health) confirmed communication with staff was open and effective. The three relatives from the dementia unit all stated that communication was good and that they were kept well informed of any incidents or changes in health status. 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. Thirteen incidents reviewed from across the service identified family were informed where required. Quarterly newsletters keep residents/families up to date.</p> <p>House meetings (aged care and mental health) occurs quarterly. Family are invited to attend. In the dementia unit relative 6 monthly meetings have been planned for 2019. 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>FA</p>	<p>St Clair Rest Home is privately owned. The service currently provides care across three service levels (rest home, dementia and residential disability-psychiatric). There is a total of 39 beds with an occupancy of 33 residents. The 13-bed Cargill unit (dementia level care) includes 10 residents (9 on ARC contract and 1 on respite). The 19-bed Ashwood unit (essentially mental health) includes 17 residents (13 on mental health contracts, 1 on an ARC contract, 3 on a LTS-CHC contract). The 7-bed Middleton unit (essentially aged care) includes 6 residents (3 on an ARC contract, 2 on an ACC contract and 1 on respite).</p> <p>St Clair Park 2018 Business Quality Risk Management Plan has been reviewed. 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 2018 quality assurance policy and plan has been reviewed. Goals are in the process of being developed for 2019. The business plan has been updated for 2019. The quality plan and</p>

		<p>business plan include current levels of care. This is an improvement on previous audit.</p> <p>The manager provides a comprehensive weekly report to the Directors. The directors meet with the manager formally at least two-monthly.</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 over 8 hours annually of training including (but not limited to) DHB training day around dementia level care and she has also completed the InterRAI managers training. She is supported by an assistant manager and two registered nurses (RN).</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></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>The service has made a number of improvements around the quality and risk management programme since previous audit. The service has contracted a mental health/aged care consultant that is supporting them around reviewing and implementation of the quality programme. Staff interviewed could describe the quality programme and felt fully informed.</p> <p>The service is working through reviewing, amending and updating policies and procedures. Considerable progress has been made since previous audit. A document control system is in place. New and amended policies are communicated to staff.</p> <p>A new meeting structure has been implemented in 2019. There are separate monthly aged care and mental health and night staff meetings. Meeting minutes reviewed identified quality data is shared through the meetings and corrective actions where required. A quality committee meets monthly and includes representatives from across the service. Quality data such as incidents and accidents, complaints and infections are presented to meetings, however this data is not broken down and analysed.</p> <p>An updated annual internal audit schedule is being implemented, and this is an improvement on previous audit. Corrective actions are documented when service shortfalls are identified. Corrective actions are signed off when completed and this is an improvement on previous audit.</p> <p>A family survey was completed in 2018 with only two returned. A resident survey was completed July 2018 and a meal survey June 2018. However, neither surveys were analysed and collated with identified corrective actions.</p> <p>The manager is currently health and safety representative and has completed external H&amp;S training. Health and safety is an agenda item of the quality committee. A generic current hazard register is in place. However, hazards identified through incident reporting, maintenance requirements and service delivery are not routinely documented and managed through the hazard reporting process. The hazard register was last reviewed 11 December 2017. Staff received health and safety training in 2018. Falls prevention strategies are in place for individual assessed residents.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>Thirteen accident/incident forms were reviewed. Individual reports are completed for each incident/accident, with immediate action noted. Shortfalls were identified around the completion of the form. The current template combines both staff and resident incidents and therefore was not always completed correctly (link 1.2.3.9) and any follow-up action(s) required. Incident/accident data is reported to quality and staff meetings (link 1.2.3.6). There was no implemented process around the identification and management of serious incidents with significant risk to residents/staff. There were five medication errors identified Feb/March. There was no documented evidence to reflect how this was fully addressed by the service.</p> <p>The manager is aware of their requirement to notify relevant authorities in relation to essential notifications. The manager reported there has been no reportable events 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>	<p>PA Low</p>	<p>There is a Consumer Participation policy. St Clair Park has quarterly resident meetings in the mental health unit. This allows residents to have input into the service. 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 survey has been completed July 2018 (link 1.2.3.6). The service continues to work toward meeting the intent of this standard by having consumers 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,</p>	<p>PA Low</p>	<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. A family survey has been completed in 2018 with only two responses. The manager advised that she is intending to invite a family member to attend the board meeting. This has not yet been implemented. The previous shortfall continues to be an area for improvement.</p>

<p>implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.</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>PA Low</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files sampled (two registered nurses, two caregivers and one support worker) included evidence of employment contracts. All had evidence of reference checks, however not all documentation was included in the files reviewed. The manager is currently completing a staff file audit to determine gaps around documentation and addressing these. Appraisals were up to date where required and this is an improvement on previous audit.</p> <p>The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Staff interviewed, including new staff, stated that new staff are adequately orientated to the service. A new orientation package has been developed and implemented since previous audit, and the service is currently working with all newer staff to complete these. There continues to be gaps around staff completing orientation documentation and this is currently being addressed and managed by the service.</p> <p>A register of practising certificates is maintained. One registered nurse is interRAI trained and the other is in training. This is an improvement on previous audit.</p> <p>First aid training has been completed by 16 of 20 staff. There is a first aider across all shifts and this is an improvement on previous audit.</p> <p>There is an annual education and training schedule and register to monitor staff training. Training has been provided regularly since the last audit, and mandatory training has been provided. This is an improvement on previous audit. The assistant manager is currently training to become a careerforce assessor. The service has linked to an aged care online training self-directed learning programme.</p> <p>One of the two registered nurses have completed smoking cessation training, and this is an improvement on previous audit.</p> <p>There are 12 caregivers that work between the rest home and dementia. There are five caregivers that have completed the dementia standards and four have also completed 'walking in another shoes". The five caregivers with the dementia standards are rostered mainly in the dementia unit. Staff have also completed management of challenging behaviours, and recognising triggers and de-escalation.</p> <p>There are six support workers that work in the mental health unit. The support workers are supported to complete level 4 Health &amp; Wellbeing and mental health and addition. Three have completed level four, two have completed level three and one is in training. The support workers have also completed online training around the role of the</p>

		support worker.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a staffing policy. The nurse practitioner for the local DHB is in daily contact with the service and provides supervision to the two RNs. The residents under a mental health contract all have an identified support worker as their key worker and this is an improvement on previous audit. The manager and staff interviewed advised that there has been a moderate turnover of staff, which has resulted in an improved staff culture.</p> <p>There are two registered nurses. One RN also works as a keyworker for the residents under residential disability-psychiatric. He rotates on a four day on and two days off roster. The other RN works three days a week with specific hours for the aged care and residents in the dementia unit&gt;</p> <p>The service is divided into three units.</p> <p>In Ashwood unit, there are 17 residents (13 mental health, four aged care including three on LTS-CHC contracts). There is 1x key worker rostered 0700 – 1530 and one support worker 0700 – 1530. There is 1x key worker rostered 1500 – 2330 and one support worker 1300 – 2130. There is one support worker in the unit overnight (2315- 0715) who also oversees Middleton unit.</p> <p>In Middleton unit, there are six residents (three aged care, two ACC and one respite). There are caregivers rostered 0700 – 1530 and 1500 – 2330.</p> <p>In Cargill unit (secure dementia), there are 10 residents. There are two caregivers on the morning shift (0700 – 1530 and 0845 – 1130). There is another caregiver/activity persons who works from 1130 – 1930. In the afternoon there is a caregiver rostered from 1500 – 2300. Overnight there is one caregiver 2315- 0715.</p> <p>There is a cleaner employed.</p> <p>Interviews with the residents, family (whānau) and staff confirmed staffing meets residents' needs.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer</p>	FA	<p>Mental Health: There have been no planned discharges since the previous audit, as appropriate for this resident group. The six-monthly MD review includes discharge planning if appropriate. One resident had been released from a compulsory treatment order and this was identified on file.</p> <p>There are discharge plan forms available to be utilised if needed for mental health residents.</p>

from services.		
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>Ten electronic medication charts were reviewed (four dementia, four rest home and two mental health). 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, support workers, and caregivers administer medicines. The facility uses a blister pack medication management system. The registered nurse reconciles the delivery of medications and informs the pharmacy of errors. 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. The temperatures are checked on the medication fridge; however, this was found to be faulty on the day of the audit.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	PA Moderate	<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, temperature checked and recorded before being served by support workers and caregivers. A dietitian reviews all menus for the contracted food services company. Staff have completed food safety training (2018) 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 all units and are emailed to the manager. The previous finding has been addressed. However, not all food in the fridges throughout the facility was dated, and not all food was stored in line with guidelines.</p> <p>Food and meals are discussed at resident meetings. Residents and relatives interviewed were complimentary of the meals provided. Snacks are available 24 hours in the dementia unit.</p>
<p><b>Standard 1.3.5: Planning</b></p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of</p>	PA Moderate	<p>Rest home and dementia: All resident care plans sampled were resident centred; there were specific care plans tailored to resident specific health needs including (but not limited to) behaviours, epilepsy, diabetes, and pain. This is an improvement on previous audit. Each resident had an end of life care plan in place. There was evidence of service integration with documented input from a range of specialist care professionals</p> <p>Mental Health: There was a variety of different documents throughout the six mental health files reviewed. The Support Plan policy included guidelines for what documents should be in in each file. Four of six files had a LTCP along with personal and wellness recovery plans. Support plans lacked the residents short and long-term goals (link</p>

service delivery.		<p>1.3.3.3). Early warning signs and relapse prevention signs were on file, but had not been reviewed since admission.</p> <p>Relatives interviewed confirmed they are very satisfied with the care delivery and support by staff. Registered nurses, caregivers 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>	FA	<p>Rest home and Dementia: Caregivers follow the care plan and report progress against the care plan at the end of each shift. Interactions between staff and residents was seen to be respectful. If external nursing or allied health advice is required, the registered nurse will discuss with the GP, who sends the referral. Residents are supported to attend clinics such as diabetic clinics. Wound care, district nursing and continence specialists are available on request.</p> <p>Residents and relatives interviewed were happy with the support provided to them.</p> <p>All current wounds (one skin ear, one resident admitted with a burn, one skin graft) have a wound assessment, plan and evaluations which describe progression or deterioration of the wound. Adequate dressing supplies sighted in all units. The GP is notified of all wounds. A wound care specialist and district nursing services are available on request. There were no pressure injuries on the day of audit.</p> <p>Continence products are available and resident files include urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RN interviewed.</p> <p>Resident's weight is monitored monthly, there were no residents with unintentional weight loss on the day of the audit. Monitoring forms sighted include (but not limited to); behaviour, seizures, falls, bowels, daily living activities, weight and vital signs.</p> <p>Mental Health: The nurse practitioner (NP) for mental health works closely with the registered nurse and liaises regularly with the GP. He works as case manager for the residents and provides support and oversight at least weekly. The recovery/support plans reviewed identified the support staff involved in the resident's care, including (but not limited to) the key support worker. All residents at St Clair Park have diagnoses of mental health conditions. Many also have aged related medical problems, interventions are identified through the LTCP (link 1.3.5.3).</p> <p>Overall support is based upon the mental health support needs assessment that informs a recovery/support plan (link 1.3.5.2). The personal and wellness recovery plans are designed to meet the person's individual needs, although personalised goals could be better documented (link 1.3.3.3). The support services available are inclusive of the person's cultural needs and contribute to meaningful, positive changes in the resident's life. Two residents interviewed under mental health contracts spoke positively about where they live, and the support provided.</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 activities coordinator has been in the role for almost a year, and works 24 hours a week in activities and continues to work towards a qualification in diversional therapy. The activities coordinator has completed the ‘walking in another’s shoes” course and has completed Careerforce dementia standards. The programme is planned weekly and deliver is supported by the caregivers and support workers. Individualised activity assessments and activity plans are completed on a six-monthly basis. 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, resident meetings and one-on-one feedback from residents (as appropriate) and families. The programme includes outings in the car, church services, a variety of group activities, dog squad, 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. There has been putting holes installed all lawn areas for residents who enjoy golfing.</p> <p>Residents and relatives interviewed commented positively on activities provided.</p> <p>Cargill unit (dementia); A review of dementia resident files evidenced that activities 24-hour care plans are evident throughout the residents’ care plan. The activities programme reflects the residents’ cognitive and physical abilities. Activities are provided to the residents by caregivers, with oversight from the activities coordinator. There is a printed sheet of ‘activities of daily living’ which is a guide of regular routines for the day. This provides suggestions of activities residents may like to engage in on the day, such as assisting with household tasks such as folding laundry, dusting, setting up morning and afternoon tea. Group activities include housie, singing groups, puzzles, and ball games. There are regular van outings. Staff complete a log of activities that has taken place on each shift and how many residents participated.</p> <p>Residents and families interviewed commented that activities meet resident needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Rest home and dementia: 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 caregivers, and reported to the registered nurse. Care plan evaluations reflect progression towards resident goals. Activities assessments and plans are in place, and are reviewed at least six monthly. This is an improvement on previous audit. Short-term care plans sighted had been evaluated and signed off as resolved. Where progress is different from expected, changes are made to the care plan. Staff stated that family members are informed of any changes to the care plan and this was evidenced in the progress notes, and interviews with family members.</p> <p>There is a process of formally reviewing recovery plans, goals and outcomes both with the resident and in a multidisciplinary setting. Documentation does not reflect that plans have been reviewed as per policy (link 1.3.3.3). The review includes the resident and with their consent, their family/whānau. A new ADL assessment tool has been</p>

		implemented along with the mental health assessment tool.
<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>The service is divided into three units; Ashwood (Mental Health) and Middleton (rest home), and Cargill (dementia).</p> <p>The building has a current building warrant of fitness that expires on 6 July 2019.</p> <p>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. Staff stated they have all the equipment required to provide the level of care documented in the care plans.</p> <p>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 been tested and recorded randomly in each unit monthly. Contractors are on call 24/7 if required. The previous finding has been addressed.</p> <p>Corridors are wide enough to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. All grounds and gardens are well maintained, with a secure outdoor area for the residents in the Cargill unit.</p> <p>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 now been implemented within the service. There are designated smoking areas on the premises for residents, and staff who smoke go off site. The previous finding has been addressed.</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>	PA Low	<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 last occurred December 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. There are adequate supplies of food stored on site for residents to last until the contracted supplier can deliver meals within two days, as described in the contract between them and St Clair Park. There is a BBQ for cooking meals. There is a supply of disposable plates and cutlery. The previous finding has been partially met. There is water stored onsite for use in an emergency, however when calculated, this does not meet requirements.</p> <p>A call bell system is in use in all areas.</p> <p>External lighting and security systems are adequate for safety and security. The service has cameras installed in</p>

		<p>the hallways and communal areas of the rest home and dementia unit.</p> <p>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.</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>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. Individual report forms are completed for all infections. A monthly infection summary is completed. The IC coordinator uses this data and completes a monthly analysis report. Outcomes and actions are discussed at the quality meeting and mental health and aged care staff meetings. There has been no reported outbreak since the last audit. Infection control internal audits are completed included hand hygiene audits.</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 completed training on restraint or enablers in 2018 and five staff have completed an online course to date in 2019.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.2</p> <p>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.</p>	<p>PA</p> <p>Moderate</p>	<p>All five resident files reviewed have signed consent to treatment forms. Resuscitation orders have been discussed and signed appropriately either by the resident or appointed EPOA, and have been reviewed on an annual basis in consultation with the GP. End of life wishes are discussed and documented. All residents have signed. Two of nine residents in the dementia unit have an activated EPOA on admission agreements on file. Relatives interviewed report they are informed of changes in resident condition where appropriate, and are involved in supporting residents in decision making as appropriate.</p>	<p>Seven of nine residents in the dementia unit do not have an activated EPOA on file.</p>	<p>Ensure all residents admitted to the dementia unit have activated EPOA on file.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p>	<p>PA</p>	<p>A new meeting structure has been implemented</p>	<p>(i). Quality data such as incidents</p>	<p>(i). Ensure quality</p>

<p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>Moderate</p>	<p>in 2019. Resident meetings are being held regularly which is an improvement on previous audit. There are separate monthly aged care and mental health and night staff meetings. Meeting minutes reviewed identified quality data is shared through the meetings and corrective actions where required. A quality committee meets monthly and includes representatives from across the service. Quality data such as incidents and accidents, complaints and infections are presented to meetings, however this data is not broken down and analysed.</p>	<p>and accidents, complaints and infections are presented to meetings, however this data is not broken down and analysed.</p> <p>(ii). A resident survey was completed July 2018 and a meal survey June 2018. Neither surveys were analysed and collated with identified corrective actions.</p>	<p>data collected is analysed and actions implemented as a result of trends identified. (ii) Ensure surveys are analysed, collated and corrective actions implemented where required.</p> <p>90 days</p>
<p>Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	<p>PA Moderate</p>	<p>The manager is currently health and safety representative and has completed external H&amp;S training. Health and safety is an agenda item of the quality committee. A generic hazard register is in place. The hazard register was last reviewed 11 December 2017. However, hazards identified through incident reporting, maintenance requirements and service delivery are not routinely documented and managed through the hazard reporting process. Staff received health and safety training in 2018.</p>	<p>(i). Hazards identified through incident reporting, maintenance requirements and service delivery are not routinely documented and managed through the hazard reporting process. (ii) The hazard register is not regular reviewed. (iii) There are a number of hazards noted during the audit including (but not limited) changes in floor service, and cluttering in area and offices that create a potential hazard. These were not identified on the hazard register. (iv) Staff incidents are not separated out of the adverse event reporting system and therefore not collated and reviewed to identify risk mitigation strategies</p>	<p>(i). Ensure hazards are identified on a daily basis and managed through the hazard management system. (ii) Ensure the hazard register is updated regularly and reviewed at least annually; (iii) Ensure environmental hazards are routinely identified and managed; (iv) Separate staff adverse events, analyse and implement risk mitigation</p>

				strategies;  90 days
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Moderate</p>	<p>Thirteen accident/incident forms were reviewed. Individual reports are completed for each incident/accident, with immediate action noted. Registered nurse assessment and follow up was documented on the form, but it was not always evident who (including designation) completed which part of the form. The current template combines both staff and resident incidents and therefore was not always completed correctly (link 1.2.3.9) including any follow-up action(s) required. Incident/accident data is reported to quality and staff meetings (link 1.2.3.6). There was no implemented process around the identification and management of serious incidents with significant risk to residents/staff. There were five medication errors identified Feb/March. There was no documented evidence to reflect how this was fully addressed by the service.</p>	<p>(i). It was not always identifiable who the writer was including designation. (ii) Incident forms were not always fully completed or completed correctly. (iii) There was no implemented process around the identification and management of serious incidents with significant risk to residents/staff. There were five medication errors identified Feb/March. There was no documented evidence to reflect how this was fully addressed by the service.</p>	<p>(i)-(ii). Review the current incident form template to ensure it includes all required areas. Ensure staff fully complete each required section including name and designation. (iii) Implement a process around management of serious incidents so that follow up is fully documented including ways to prevent reoccurrence</p> <p>60 days</p>
<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>Resident meetings are held, and resident surveys are completed. However, the service does not have a consumer advisor or representative although the manager stated they are working towards this. The service does not fully demonstrate that residents participate at all levels of service delivery</p>	<p>The service cannot fully demonstrate that consumer participation is evident across all levels of service delivery</p>	<p>Ensure residents have participation in planning, implementation, and monitoring of service delivery</p> <p>90 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>There is a comprehensive policy outlining the processes to engage families at all levels of the service. A relative's survey in 2018 has been completed. Advised that overall, not many families have close involvement with the resident or the service. The manager has identified corrective actions to meet this standard that are yet to be fully implemented.</p>	<p>The processes described in policy to involve family in all levels of the service are not fully implemented</p>	<p>Ensure there is family/whānau input into planning, implementation, monitoring and evaluation of service delivery</p> <p>90 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>Five staff files sampled (two registered nurses, two caregivers and one support worker) included evidence of employment contracts. All had evidence of reference checks, however not all documentation was included in the files reviewed. The manager is currently completing a staff file audit to determine gaps around documentation and addressing these. Two of five staff files had all required employment documentation on file.</p>	<p>Three staff files reviewed did not have all required employment documents on file.</p>	<p>Ensure staff files include all required employment documentation</p> <p>90 days</p>
<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 Low</p>	<p>Staff reported that new support workers receive a comprehensive orientation that can be extended if required. One staff member was orientated to the dementia unit during the audit and could describe the buddy process. A new orientation package has been developed and implemented since previous audit. The service is currently working with all newer staff to complete. Three of five staff files reviewed contained documentation of a completed orientation.</p>	<p>Two of five files did not have a completed orientation package. There is a corrective action implemented by the service around addressing this and the manager is working with all new staff to ensure all staff complete this. Therefore, the risk has been identified as low.</p>	<p>Ensure all staff have completed orientations and these are on staff file.</p> <p>90 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>All electronic medication charts have photographic identification, and allergies documented. Medicine reconciliation is completed by the RN. The lunchtime medication rounds sighted were compliant with legislation. All staff who administer medications have current medication competencies, including insulin competencies. All charts have been reviewed on a three-monthly basis by the GP. Medications are stored in a locked cupboard in a locked room in all units, there were no expired drugs. Temperatures were recorded in the medication fridge, however the fridge in the nurse's office was found to be faulty.</p>	<p>Boxes of insulin in the medication fridge in the nurse's station were wet, as the ice box had defrosted.</p>	<p>Ensure the medication in the medication fridge is checked regularly.</p> <p>30 days</p>
<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>All food is prepared and cooked off site, and delivered to St Clair Park in hot boxes or covered trays. Temperatures of meals are recorded in the service for each meal. Fridge temperatures are obtained and recorded daily. Advised that all food is removed and disposed of within 24 hours arriving to the facility.</p>	<p>i) Decanted breakfast cereals in the units do not indicate expiry dates.</p> <p>ii) Food in the fridges in two of the units was covered but not dated. This was corrected on the day of the audit.</p> <p>iii) There was leftover food stored in one unit that should have been stored in the fridge.</p>	<p>(i) Ensure all decanted food indicates the expiry date.</p> <p>(ii) – (iii) Ensure all food is stored appropriately</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the</p>	<p>PA Low</p>	<p>A sample of six hard copy resident files were reviewed (two residents on mental health contracts, two dementia level and two rest home including one resident on an ACC contract). The four files reviewed across the rest home, and dementia unit met required</p>	<p>Four of six mental health files reviewed identified that recovery/support plans do not have specific resident goals that were reviewed three monthly.</p>	<p>Ensure mental health files include a recovery/support plan with specific goals that are reviewed three</p>

needs of the consumer.		ARCC contract timeframes.  Mental Health: A number of assessments were completed on admission. The mental health assessment was evident in all files reviewed. The mental health files did not evidence regular reviews and therefore the sample was increased to six mental health files to review around timeframes. Four of six mental health files reviewed identified that recovery/support plans do not have specific resident goals that were reviewed three monthly.		monthly with a formal review at least six months  90 days
Criterion 1.3.5.4  The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/ whānau if appropriate.	PA Moderate	There was a variety of different documents throughout the six mental health files reviewed. The support plan policy included guidelines for what documents should be in each file. Four of six files had a LTCP along with personal and wellness recovery plans. Support plans lacked the residents short and long-term goals (link 1.3.3.3). Early warning signs and relapse prevention signs were on file but had not been reviewed since admission.	(i) Two of six files did not have a LTCP in place or all required documents as per policy.  (ii) There was a regular short-stay resident recovering from post ECT treatment with no documentation including assessment, or care plan in place.  (iii) Early warning signs and relapse plans were placed on admission with no evidence of review.  (iv) The Personal recovery action plan for one resident included the name of another resident.	(i)-(ii). Ensure documentation is consistent and completed across all mental health residents including short-stay. (iii) Ensure all residents have a current early warning signs and relapse plans in place. (iv) Ensure documentation for each resident is personalised for that resident.  90 days
Criterion 1.4.7.4  Alternative energy and utility sources are available in the	PA Low	Power is available in the facility for up to two hours following a power outage. Staff and management interviewed confirmed there are	The service does not store adequate water supplies in the event of a civil defence	Ensure the service has supplies of water

<p>event of the main supplies failing.</p>		<p>no supplies in the event of a civil defence emergency. Extra blankets are available. There are snacks available and enough extra food to meet civil defence requirements.</p>	<p>emergency.</p>	<p>as per civil defence guidelines.</p> <p>30 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.