

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

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:

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| Legal entity: | St Clair Park Residential Centre Limited |
| Premises audited: | St Clair Park Residential Centre |
| Services audited: | Rest home care (excluding dementia care); Dementia care; Residential disability services - Psychiatric |
| Dates of audit: | Start date: 7 November 2019 End date: 8 November 2019 |
| Proposed changes to current services (if any): | None |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 33 |



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

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 second 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 has been in the role since December 2017. The manager is supported by an assistant manager and a registered and enrolled nurse. Feedback from residents and families was positive about the care and services provided.

The service continues to work through their previous audit shortfalls with support by a quality consultant (RN). Processes and systems are being reviewed and updated. Further systems continue to be developed and established. A number of improvements have been noted since last audit which include environmental improvements to gardens and establishing processes around ECT recovery and respite care.

Seven of the thirteen shortfalls from the previous audit have been addressed. These were around consent, orientation, quality programme, mental health goals, mental health client files, food safety and civil defence.

Further improvements continue to be required around hazard management, adverse event management, staffing, resident and family participation, and medication documentation.

This audit has also identified improvements required around open disclosure, policies/procedures, registered nurse follow-up, interventions, wound documentation, self-medicating, and building warrant of fitness.

Consumer rights

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| 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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Management have an open-door policy. Complaints and concerns have been managed and a complaints register is maintained. Residents and relatives feel well informed and are comfortable discussing issues with management.

Organisational management

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| 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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The quality and risk management programme includes service philosophy, goals and objectives. Meetings are held to discuss quality and risk management processes. There is a health and safety management programme available to guide staff. Resident meetings are held regularly in the Ashwood (mental health) and Middleton (rest home) units. Incidents and accidents are reported. There are human resources policies to support recruitment practices. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme for 2019 is implemented. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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The registered nurse is responsible for the provision of care and documentation at every stage of service delivery. The residents and relatives interviewed confirmed their input into care planning. The residents each have a care plan, and these are reviewed at least six monthly. There is a documented electronic medicine management system in place. Support workers across the mental health unit support residents in developing and meeting short and long-term goals.

Planned activities are appropriate to the group setting. The residents and relatives interviewed commented positively on the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Meals are prepared by an external contractor and delivered to the facility. Nutritional requirements are met. Nutritional snacks are available 24 hours a day.

Safe and appropriate environment

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| 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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Reactive and preventative maintenance occurs. There is adequate space throughout the facility for residents to move around freely. External areas are well maintained. Fire drills are held six monthly and a civil defence kit including water is in place.

Restraint minimisation and safe practice

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| 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 remains restraint free. Education has been provided in the past 12 months and during orientation around challenging behaviour, de-escalation and restraint minimisation.

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.

St Clair Park has an infection control programme in place which has been reviewed annually. The infection control programme is designed to link to the quality and risk management system. Records of all infections are maintained electronically, analysed for trends and discussed at all meetings.

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) |
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| Standards | 0 | 11 | 0 | 5 | 6 | 0 | 0 |
| Criteria | 0 | 48 | 0 | 6 | 7 | 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) |
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| Standards | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 0 | 0 | 0 | 0 |

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | 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 (link 1.1.9.1). All residents have a signed admission agreement and general consent form on file, and all residents in the dementia unit have activated EPOAs on file. The previous finding has been addressed. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is | FA | The service has a complaints policy that describes the management of the complaints process. Information about complaints is provided on admission to residents and their relatives/whānau. Feedback forms are available for residents and families/whānau in the foyer. Staff (four caregivers, one enrolled nurse and one registered nurse) interviewed were able to describe the process around reporting complaints. There is a complaint’s register. Two complaints have been made since the previous audit. All complaints reviewed had written investigations, timeframes and where required, corrective actions were documented and implemented. Results and outcomes of |

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| understood, respected, and upheld. | | the investigations are fed back to complainants. Discussions with residents and relatives confirmed that any issues are addressed, and they feel comfortable to bring up any concerns with the management. |
| Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | <p>Accident/incidents, complaints procedures and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident. Fifteen incidents/accident forms reviewed (five from each service level) include a section to record family notification, however not all forms evidenced family were informed, or if they wished to be. Four relatives interviewed (all with family members in the dementia unit) confirmed that they are notified of any changes in their family member's health status. The relatives and three residents from mental health and two rest home residents interviewed stated they felt communication was open and they were well informed of changes. Meetings are held six weekly in the Ashwood (mental health) unit and quarterly in Middleton (rest home) unit, one relative meeting was arranged earlier this year with no attendance, another is planned.</p> <p>An interpreter policy and contact details of interpreters is available.</p> |
| Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | <p>St Clair Park 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 16 residents (12 on mental health contracts, 2 on an ARC contract, 2 on an LTS-CHC contract). The 7-bed Middleton unit (essentially aged care) includes 7 residents (4 on an ARC contract, 2 on an ACC contract and 1 on respite).</p> <p>St Clair Park 2019 Business Quality Risk Management Plan is being implemented. 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 2019 quality assurance policy and plan contain goals and objectives to include improvements across all levels of care.</p> <p>The manager provides a comprehensive monthly report to the directors. The directors meet with the manager formally at least three-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 eight hours annually of training and attends the DHB age care meetings and the two weekly meetings for mental health (single point of entry meetings). She is supported by an assistant manager, two registered nurses (one of whom is on maternity leave) and an external quality consultant.</p> |
| Standard 1.2.3: | PA | St Clair Park continue to make improvements around the quality and risk management programme since previous |

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| <p>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>Moderate</p> | <p>audit. The mental health/aged care consultant continues to support the service around further establishing and implementing of the quality programme. The consultant visits around six to eight weekly. Staff interviewed could describe the quality programme and felt fully informed.</p> <p>Initiatives implemented since the last audit include improving the external area of Cargill (dementia) unit. This included (but not limited to) introducing strawberry towers, a covered fishpond and painting toilet doors red to be easily identifiable. The service has also increased the respite resident numbers. There is a new initiative around providing a day programme for four people across seven days. Staffing has already been increased in preparation. There is a dedicated room for people recovering from ECT treatment in the Ashwood unit, and there has been a project around formatting the assessments and care plans to be more goal focused in the unit. In the Middleton (age care) unit, staff have a focus on maintaining diversity and individualising care.</p> <p>The service has recently employed an administration assistant.</p> <p>The service continues to work through reviewing, amending and updating policies and procedures, however due to the number of corrective actions required from their last audit the service has not been able to focus on reviewing and updating policies. This is an area that requires improvement. New and amended policies are communicated to staff at the monthly staff meetings.</p> <p>A new meeting structure and minutes template has been implemented since the last audit. Each month there is a combined quality meeting to include infection control and restraint, with extra time for health and safety matters. This is followed by a 'whole staff meeting' and allows extra time at the end for Ashwood staff to have a meeting specific to their unit. The meeting minute template has been altered to include all data, analysis and any trends identified. All minutes are available for staff to read. This is an improvement since the last audit.</p> <p>An annual internal audit schedule is being implemented, corrective actions are documented when service shortfalls are identified and signed off when completed, results are discussed at the meetings.</p> <p>A satisfaction survey was completed in July 2019 with only four responses returned (two relatives from the dementia unit and two age care residents). The results showed overall satisfaction with the service, results were discussed at a staff meeting, and corrective actions made around laundry services, as one respondent was less satisfied around this area. A more recent survey was completed in November 2019, just prior to this audit. Results had not been collated; more responses were received. St Clair Park has contracted a mental health consumer advisor, who has not yet made contact with the facility (link 1.2.5.1). This is planned to be followed up and reviewed in the new year. The November surveys were conducted by a student social worker.</p> <p>The manager is currently the health and safety representative and has completed external H&S training. Health and safety is an agenda item of the quality committee. Staff have received training on quality, risk and health and safety in July 2019. The risk and hazard register was reviewed and updated in July 2019 and has been divided in to two areas – environment (which includes building and environmental hazards), and organisation which includes (but not limited to); hazards relating to people such as challenging behaviours, falls as a result of medications, and management of systems. Corrective actions are signed off when completed by maintenance. The previous finding</p> |
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| | | <p>has been addressed around the hazard documentation; however, office spaces remain small and cluttered, this was not identified in the environmental hazard register, this is an ongoing shortfall.</p> <p>Incident reporting has been reviewed and is now separated into service levels and staff. These are analysed for trends and discussed at meetings. The previous finding has been addressed (link 1.2.4.3).</p> <p>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>Eighteen incident forms were reviewed. Individual reports are completed for each incident/accident, with immediate action noted by the first staff member on the scene. Shortfalls continue around the completion of the form. The staff member completing the incident form signs the form and indicates their designation; this is an improvement from the previous audit, however, clinical follow up, and notifications made (link 1.1.9.1) following adverse events was not always documented on the form or in the progress notes. Neurological observations were not always evidenced as occurring following unwitnessed falls.</p> <p>Incident/accident data is reported to quality and staff meetings and trends were identified where possible. Following a series of medication errors, an investigation process was carried out by the manager and the registered nurse. Processes are in place to increase monitoring and oversight to reduce further errors. Medications are an ongoing agenda item at all meetings, issues, corrective actions and discussions are held. The previous finding has been addressed around management of serious incidents.</p> <p>The manager was aware of their requirement to notify relevant authorities in relation to essential notifications. The manager reported there have been police notifications of missing medication reported 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 2019. The service managed to access a consumer advisor following the previous audit. A contract was established with the advisor and the service; however, since the contract was signed the consumer advisor has not been able to be reachable and therefore has not yet been involved with the service. This continues to be an area requiring improvement.</p> |

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| <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> | <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. There has been no family survey for mental health relatives in the last year. The manager has contacted all family members to try and gather some interest from family in an advisory role, however there has been no interest. The previous shortfall continues to be an area for improvement.</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 Moderate</p> | <p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files sampled (one registered nurse, one enrolled nurse, two caregivers and one support worker) included evidence of employment contracts. All had evidence of reference checks, and appropriate documentation on file. 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 a recently employed staff member, stated that new staff are adequately orientated to the service. The orientation package has been reviewed again and implemented since previous audit to include competencies on medications including insulin, infection control and hand hygiene, health and safety, restraint, challenging behaviour, abuse and neglect, the aging process, residents' rights and the role of the support person. A specific competency for staff working in the dementia unit is around 24-hour diversional therapy. For staff in the Ashwood (mental health), there is a competency on the recovery approach. An electronic spreadsheet is maintained and indicates all staff have completed these competencies either on orientation or as ongoing education.</p> <p>First aid training has been completed by all staff, and there is a first aider across all shifts. A file with current practicing certificates is maintained.</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. The assistant manager continues to work through becoming a Careerforce assessor. The service has linked to an aged care online training self-directed learning programme.</p> <p>One RN (currently on maternity leave) of the two registered nurses have completed smoking cessation training. The enrolled nurse is currently completing interRAI training. The registered nurse on maternity leave is interRAI trained, and training is planned for the current registered nurse.</p> |

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| | | <p>There are 12 caregivers that work between the rest home and dementia unit. All caregiver staff working in dementia have worked there less than six months. There are currently no caregivers working in the unit that have completed the dementia standards. Four caregivers are currently completing the dementia standards, two of these have completed two of the four standards. 'Walking in another's shoes' is offered to staff working in the dementia unit. There are some staff that have completed this, but exact numbers were not available.</p> <p>Due to a recent turnover of staff in the dementia unit, and the use of regular agency staff, it was noted there was a lack of experienced caregivers in the dementia unit. The current registered nurse has a background in mental health with little aged care experience. There is a dementia nurse practitioner who visits the site four to six weekly for advice and oversight. Advised that the assistant manager has the responsibility of the day to day running of the dementia unit and is qualified Level 4 aged care including dementia and is currently working toward DT.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>There is a staffing policy. The mental health nurse practitioner for the local DHB is in weekly contact with the service, and is the combined role of the prescriber, case manager and responsible clinician for the clients in the Ashwood (mental health) unit. The nurse practitioner is on 24-hour call to the service for advice be email or phone. The nurse practitioner visits on the same day as the GP so combined assessments can occur.</p> <p>The residents under a mental health contract all have an identified support worker as their key worker. The manager interviewed advised that there has been a high turnover of staff. With all the new staff, the manager is working on building on teamwork, an improved staff culture and focusing on a resident-centred process.</p> <p>There are two registered nurses (one currently on maternity leave). The current registered nurse works across the facility from Monday to Thursday each week. The non-clinical managers are available on call for non-clinical matters, and the registered nurse is on call for clinical matters.</p> <p>The service is divided into three units.</p> <p>In Ashwood unit, there are sixteen residents (twelve mental health, two aged care, and two on LTS-CHC contracts). There is 2x key workers rostered 7 am to 3.30 pm and one support worker 8.30 am to 3.30 pm. There is 1x key worker rostered 3 pm to 11.30 pm and one support worker 1 pm to 9.30 pm. There is one support worker in the unit overnight (11.15 pm to 7.15 am) who also oversees Middleton unit, and supports the caregiver in Cargill (dementia) unit.</p> <p>In Middleton unit, there are seven residents (four aged care, two ACC and one respite). There is one caregiver rostered 7 am to 3.30 pm and one caregiver from 8.30 am to 1 pm. One caregiver is rostered 3 pm to 9.30 pm.</p> <p>In Cargill unit (secure dementia), there are ten residents (including one on respite). There is one caregiver rostered 7 am to 3.30 pm, one caregiver from 7 am to 11 am and one caregiver from 10 am to 9 pm. There is one caregiver in the afternoon from 3 pm to 11.30 pm and one caregiver overnight from 11.15 pm to 7.15 am. The night shift is currently filled by agency staff when required. The manager has requested the same pool of staff to cover the unit</p> |

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| | | <p>to provide consistency. Activities/assistant manager is rostered in the unit from 2 pm to 5 pm each day Monday to Friday.</p> <p>The cleaner in the Cargill unit is rostered from 9 am to 11 am each day who competes housekeeping and makes residents beds. A cleaner is employed for the rest of the facility each day.</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 from services.</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 is currently going through a transition process to St Clair Park from hospital with the hospital providing the transition plan. A transition plan is in place that covers discharge.</p> <p>There are discharge plan forms available to be utilised if needed for mental health residents.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | PA Moderate | <p>Eight electronic medication charts were reviewed across dementia and rest home and five medication charts across mental health. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complied with the medication management policy for the medication rounds sighted. Medication competent registered nurse, and medicine competent caregivers/support workers administer medicines. The facility uses a blister pack medication management system and medimap. 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 for all residents admitted for long-term care. 'As required' medications have been correctly prescribed indicating reason for administration. There was one respite resident who self-administers medications in the Middleton unit, however not all required documentation was in place. The temperatures are checked on the medication fridge and recorded each time the registered nurse is on duty. These were all within required ranges. The previous audit finding has been addressed.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> | FA | <p>All service levels: All food is prepared and cooked off-site by an external contractor and delivered in hot boxes at mealtimes. It is then transferred into bain maries, temperature checked and electronically recorded before being served by support workers and caregivers. This is a new initiative since the previous audit. If the temperature checks have not occurred or are outside the range, an email is sent to the contractor and the facility manager. A dietitian reviews all menus for the contracted food services company. A current food control plan is in place. Staff</p> |

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| <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | | <p>have completed food safety training (August 2019) 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. There were no residents who were losing weight unintentionally on the days of the audit.</p> <p>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. All food in the fridges throughout the facility was dated and stored in line with guidelines. The previous finding has been addressed.</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>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>PA Moderate</p> | <p>Aged Care – Overall, the long-term resident files reviewed had an individualised care plan in place, which contained individualised interventions for caregivers to provide care for residents. Separate end of life care plans continue to be discussed with the GP, residents and relatives and are in place in resident files, however not all care plans included interventions to reflect resident current need.</p> <p>Mental Health: The support plan policy included guidelines for what documents should be in each file. Mental health files reviewed included updated templates, and this is an improvement on previous report. Support plans reviewed included short and long-term goals. All resident files reviewed included an ADL ability/support plan which identified support and assistance needed. Early warning signs and relapse prevention signs were on file and reviewed as part of the support plan review.</p> <p>The service provides short stay recovery regularly for three residents post ECT. One file reviewed included a resident specific general plan, an emergency plan and monitoring chart, this is an improvement on previous audit.</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>PA Low</p> | <p>Aged Care: When a resident's condition alters, the registered nurse initiates a review and if required a GP visit. 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. Caregivers follow the care plan and report progress against the care plan at the end of each shift.</p> <p>There was one current wound (pressure injury stage two) in the rest home area. A short-term care plan was in place which provided instructions around keeping the dressing dry in the shower, and pressure relieving strategies, however there was no evidence of a wound chart for the wound. Adequate dressing supplies were sighted to be available in each of the three units.</p> |

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| | | <p>Continence products were available and resident files included 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 registered nurse and enrolled nurse 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 included (but were not limited to); behaviour, falls, bowels, daily living activities, weight and vital signs. Residents and relatives interviewed were happy with the support provided to them.</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 service has support from a quality consultant who also specialises in mental health. All residents at St Clair Park have diagnoses of mental health conditions. Many also have age-related medical problems, interventions are identified through the LTCP (link 1.3.5.2).</p> <p>The personal and wellness recovery plans are designed to meet the person's individual needs. The support services available are inclusive of the person's cultural needs and contribute to meaningful, positive changes in the resident's life. The residents are supported to maintain outside interests and community involvement. Resident goals often include achieving community activities. Three residents interviewed under mental health contracts confirmed satisfaction with their home 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 18 months and works 20 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 monthly and delivery 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 is focusing on more resident led activities especially in the Ashwood (mental health) unit. The activity's coordinator provides an activity plan for the two aged care residents (previously on the MH contract) residing in the Ashwood unit.</p> <p>The service receives feedback and suggestions for the programme through surveys, resident meetings and one-on-one feedback from residents (as appropriate) and relatives. The programme includes outings in the car, a variety of group activities, dog squad, arts and crafts, 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 in each unit. Residents are supported to engage in activities of their choice in the community. Celebrations are held, most recently around Halloween, where residents in the Middleton unit made pumpkin soup and participated in crafts around the Halloween theme.</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 activity's coordinator. There is a</p> |

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| | | <p>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, and helping load the dishwasher. Group activities include housie, singing groups, puzzles, sensory activities and group games. There are regular van outings. Staff complete a log of activities that has taken place on each shift and how many residents participated. This is reflected in individual progress notes. The activities coordinator collates this information and records a monthly progress note. The activities coordinator has been rostered to spend three hours on weekday afternoons in the Cargill area, this is a new initiative since the previous audit.</p> <p>Overall, residents and relatives interviewed commented positively on activities provided.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Aged Care: Care plans reviewed had been evaluated by RNs six-monthly, and overall when changes to care occurred (link 1.3.5.2). Written evaluations describe the resident's progress against the resident's (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The GP reviews residents at least three-monthly or when there is a change in health status. The relatives interviewed confirmed they are invited to attend the GP visits and multidisciplinary care plan reviews.</p> <p>Mental Health: There is an implemented process of formally reviewing recovery plans, goals and outcomes both with the resident and in a multidisciplinary setting. Evaluations were up to date in files reviewed. The review included the resident and with their consent, their family/whānau. Strengths assessment tools are also on each file.</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> | PA Low | <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, tagged, and calibrated. Staff stated they have all the equipment required to provide the level of care documented in the care plans. Hot water temperatures have been tested and recorded randomly in each unit monthly. Contractors are on call 24/7 if required.</p> <p>There is no current building warrant of fitness in place. There is a letter on file informing of the building safety and is fit for use, but as regular check were not signed as being checked in the last year, a warrant cannot be issued until August 2020.</p> <p>There are three units in St Clair Park. Cargill is the dementia unit. There is planned refurbishments in place to include a second quiet lounge area adjacent to the current dining/lounge area. Refurbishments to resident rooms are occurring when rooms become available. Toilet doors have been painted to be more distinguishable for residents and there have been improvements made to the external garden areas since the previous audit.</p> <p>Ashwood is the mental health unit; plans are in place to upgrade and refurbish the unit to be more homely. There is adequate space for clients to move around safely throughout the unit, with safe external access to the well-</p> |

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| | | <p>maintained garden.</p> <p>Middleton is the rest home unit; there is a large open plan kitchen, dining, lounge area, with an adjacent smaller lounge area. There is adequate space for residents to feely move around using mobility aids. There is safe access to external garden areas.</p> <p>A gardener has been employed to care for the external garden areas.</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>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | FA | <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/training last occurred August 2019.</p> <p>A civil defence plan is in place. Civil defence kits and first aid kits internal audit was last completed September 2019. 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 water stored on site for use in an emergency. A large 100 litre water tank has been installed and this is an improvement on the previous audit.</p> <p>A call bell system is in use in all areas and emergency three bells can be heard from all units.</p> <p>External lighting and security systems are adequate for safety and security. The service has cameras installed in 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.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed</p> | FA | <p>The infection control officer (RN with oversight from the quality consultant) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. An individual infection surveillance chart is completed per resident for each identified infection. Surveillance data is available to all staff, infections are reviewed monthly and discussed at meetings. An IC monthly analysis is completed. There have been no outbreaks since the previous audits.</p> |

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| objectives, priorities, and methods that have been specified in the infection control programme. | | |
| Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised. | FA | The policies and procedures include definitions, processes and use of restraints and enablers. St Clair Park is restraint free. On the day of audit, there were no residents with restraint and no residents using enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours in June 2019, all staff have completed restraint training either during orientation or annually. Restraint is discussed at all quality and staff meetings. |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p> | PA Low | The relatives interviewed felt they were promptly informed following adverse events; however, this was not always documented on the form or in the progress notes as having occurred including notification to the general practitioner (GP) following adverse events involving medications. | There was no documented evidence of relative or GP notifications made following adverse events. | <p>Ensure all notifications made are documented following adverse events.</p> <p>90 days</p> |
| <p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and</p> | PA Low | St Clair Park have policies and procedures in place, and have been working through reviewing and renewing these, however, have not made any progress since the previous audit. | Policies and procedures have not been reviewed as planned. | Ensure all policies and procedures are reviewed and updated to ensure they align with |

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| are reviewed at regular intervals as defined by policy. | | | | current practice. 180 days |
| <p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p> | PA Moderate | The hazard management has been reviewed and all corrective actions are signed when completed and discussed at meetings. Staff interviewed could describe processes around hazard identification, minimisation and reporting, however office spaces remain potential hazards and were not identified in the environmental hazard register. | Small cluttered office spaces were not identified as a potential hazard in the environmental hazard register. | Ensure all hazards are identified and included in the hazard register. 60 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> | PA Moderate | Incident reports are documented following adverse events. The signature and designation is clearly documented, however not all incident forms evidenced follow-up on the incident report or the progress notes. The service has had a number of medication errors which have all been investigated and managed. However, the GP has not been notified at the time to ensure the resident was safe during this time. | <p>(i) Two rest home and three dementia incident reports did not evidence clinical assessment or follow-up by the registered nurse was not documented following adverse events.</p> <p>(ii) Neurological observations were not evidenced as occurring</p> | <p>(i) Ensure all adverse events have clinical assessment and follow-up is documented.</p> <p>(ii) Ensure neurological observations are recorded following</p> |

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| | | | <p>following two unwitnessed falls with the potential for a head injury in the dementia unit.</p> <p>(iii) Notifications to the GP were not evident following two medication errors in the rest home unit. There was no documented evidence of notification to the Mental health practitioner of five medication errors in the mental health unit.</p> | <p>unwitnessed falls.</p> <p>(ii) Ensure all medication errors are managed to ensure the safety of the resident.</p> <p>30 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> | PA Low | <p>Resident meetings are held, and resident surveys are completed. Since the previous audit the service established contact with a consumer advisor. A contract was signed between the service and the consumer advisor; however, since the contract was signed the consumer advisor has not been able to be reachable and therefore has not yet been involved with the service.</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> | PA Low | <p>There is a comprehensive policy outlining the processes to engage families at all levels of the service. There has been no family survey with mental health relatives in 2019. The manager has contacted all family members to try and gather some interest from family in an advisory role, however there has been no interest.</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</p> |

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| | | | | delivery. 90 days |
| <p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p> | <p>PA Moderate</p> | <p>The orientation programme for all staff has been reviewed and now includes competencies. Staff working in the dementia unit complete competencies on the aging process, 24-hour diversional therapy, and challenging behaviour. There has been a high staff turnover and as a result there are currently no caregiver staff working in the dementia unit that have completed the dementia standards. Advised that the assistant manager has the responsibility of the day to day running of the dementia unit and is qualified Level 4 aged care including dementia and is currently working toward DT. Caregivers are being supported to complete the required dementia standards within the required timeframe. The registered nurse, employed to cover the permanent RN maternity leave, has a background in mental health. There is some clinical oversight by the dementia nurse practitioner.</p> | <p>There has been a high staff turnover and as a result there are currently no staff working in the dementia unit that have completed the dementia standards. The registered nurse providing clinical oversight has little experience working with residents with dementia.</p> | <p>Ensure there is sufficient staff experienced in dementia care working in the dementia unit.</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 Moderate</p> | <p>All required electronic medicine charts and documentation was in place for all residents admitted for long-term care in St Clair Park. This included photographic identification, evidence of three-month reviews, and allergies were identified, however, one respite resident did not have a current list of medications or medications chart prescribed.</p> | <p>One respite resident did not have a drug chart in place for current medications including controlled drugs.</p> | <p>Ensure all residents residing at the facility have current drug charts or accompanying documentation in place in line with legislation.</p> <p>60 days</p> |

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| <p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p> | <p>PA Moderate</p> | <p>There was one respite resident who was self-administering medications. Medications were safely stored; however, there was no competency assessment completed.</p> | <p>There was no self-medicating competency in place for the resident self-administering medications including controlled drugs.</p> | <p>Ensure all residents who choose to self-medicate medicines have a competency in place.</p> <p>30 days</p> |
| <p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p> | <p>PA Moderate</p> | <p>Aged Care: Progress notes are documented at the end of each shift by the caregivers in the Cargill and in the Middleton units, which document events throughout the day, food and fluid intake and activities the residents participated in during the shift, and adverse events, however registered nurse input into progress notes were not evident.</p> | <p>(i) There were no progress notes documented following adverse events, wound care, or when a resident was transferred to and from hospital.</p> <p>(ii) There was no documented evidence of registered nurse oversight of residents in the Cargill or Middleton units.</p> | <p>Ensure the registered nurse documents all adverse event follow-ups and regular reviews of residents.</p> <p>30 days</p> |
| <p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p> | <p>PA Moderate</p> | <p>The care plan templates have been reviewed recently to be more concise and streamlined. The template is on electronic format (to replace the previous handwritten format), and overall provides information for caregivers to provide individualised care for residents. However, interventions, where there is a change in health status the care plan has not always been updated to reflect current assessed needs. The templates are printed and in the resident files for caregivers to access.</p> | <p>(i) One resident on respite in the dementia unit did not have interventions in the care plan updated to reflect current behaviours identified. This was amended during the audit.</p> <p>(ii) One resident in the</p> | <p>(i)-(ii) Ensure care plan interventions are reflective of all resident current needs. (iii). Ensure documentation in files is up to date and reflects current</p> |

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| | | | <p>rest home did not have current interventions in place around diabetes management, spirituality, cultural preferences or nursing interventions for pain management.</p> <p>(iii) One resident in mental health under an LTS-CHC contract did not have an up-to date care plan (last reviewed December 2018), that reflected all current assessed needs. The resident also insulin-dependent had a diabetic management plan in the file that was out of date. There were a number of old notes within the residents file and therefore it was difficult to determine what was current or not.</p> | <p>needs.</p> <p>60 days</p> |
| <p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p> | <p>PA Low</p> | <p>A short-term care plan was in place with photos of the injury. There were instructions for the caregivers on pressure relieving strategies, the resident is able to move position regularly and an off-loading dressing was photographed to be in place, however there was no wound chart or documentation in the progress notes following dressing changes (link 1.3.3.4).</p> | <p>There was no wound documentation (assessment, plan or evaluation) recorded for a current pressure injury.</p> | <p>Ensure all wounds have a wound chart to reflect an assessment, plan and evaluation indication progression towards</p> |

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| | | | | healing. 90 days |
| <p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p> | PA Low | <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, tagged, and calibrated. Staff stated they have all the equipment required to provide the level of care documented in the care plans. Hot water temperatures have been tested and recorded randomly in each unit monthly. Contractors are on call 24/7 if required.</p> <p>There is no current building warrant of fitness in place. There is a letter on file (dated 1 August 2019) from the Dunedin City Council informing of the building safety and is fit for use, but regular safety (exit door) checks were not signed as being completed in the last year. The service has employed a contractor to carry out the inspections, maintenance and reporting for the systems on the compliance schedule. However, a year of records must be shown to the council before they will issue a BWOF and that won't be until August 2020.</p> | <p>There is no current building warrant of fitness in place. There is a letter on file (dated 1 August 2019) from the Dunedin City Council informing of the building safety and is fit for use, but as regular safety (exit door) checks were not signed as being completed in the last year, a warrant cannot be issued until August 2020.</p> | <p>Ensure all compliance checks are completed and a BWOF is issued as directed by the Dunedin City Council.</p> <p>180 days</p> |

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.