



## SOUTH CANTERBURY DISTRICT HEALTH BOARD

### CORRECTIVE ACTION PLAN

Corrective Action Timeframes identified in the report to be received by DAA Group Limited by:

<b>Timeline</b>	<b>Report to DAA Group Ltd by</b>		
6 months	8 Aug 2011	Received:	Aug 2011
9 months	1 Nov 2011	Received:	Nov 2011
12 months	8 Feb 2012	Received:	

## CORRECTIVE ACTION PLAN

1. Health and Disability Services (Core) Standards							
Std	Criteria	Rating	Corrective action Required (What is to be achieved)	Proposed Action (How it will be achieved)	By When	Actual	Auditor Response
1.2.7	1.2.7.5	PA Low	<p>Ensure that all clinical associates, who are involved in 'specialling' patients, receive appropriate training.</p> <p><b>Named Responsibility:</b> Director of Nursing, Midwifery and Allied Health</p>	<p><b>Finding:</b> Clinical associates receive training relevant to their role. However, there is no training offered to clinical associates in relation to 'specialling' of patients.</p> <p><b>Action Plan:</b> Specialling Policy in draft. To be sent to Clinical Council for approval. Clinical Associates to undergo 'specialling' training, to be delivered via the Staff Development Unit Self Learning package to be developed for registered and enrolled nurses.</p> <p><b>Progress: August 2011</b> <i>The Specialling Policy is currently in draft, to be sent to Clinical Council once finalised. The self learning package for registered and enrolled nursing staff and the "specialling" training package for clinical associates have been developed. Clinical Associate Training commenced in August, with a further study day planned for September 2011. An annual study day is planned to ensure that all new clinical associates receive specialling training.</i></p> <p><b>Progress: October 2011</b> <i>Training record attached.</i></p>	8 Aug 2011	Aug 2011	<p><b>29 August 2011</b> Action accepted. Please provide a copy of the training record from August and September.</p> <p><b>15 November 2011</b> <b>Auditor Comment:</b> Action accepted. Training record viewed. To be reviewed at audit</p>

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1. Health and Disability Services (Core) Standards							
Std	Criteria	Rating	Corrective action Required (What is to be achieved)	Proposed Action (How it will be achieved)	By When	Actual	Auditor Response
1.2.8	1.2.8.1	PA Low	<p>Develop a documented process to identify patient acuity variances.</p> <p><b>Named Responsibility:</b> Director of Nursing, Midwifery and Allied Health / General Manager Secondary Services</p>	<p><b>Finding:</b> There are initiatives and draft plans which inform the organisation about provider levels and skill mixes; however, there is no clearly documented process to identify patient acuity variances to support the staffing model.</p> <p><b>Action Plan:</b> SCDHB staff to visit two south island district health boards to look at the Patient Acuity Variance Systems that they have in place in April – May 2011. Recommendations regarding Patient Acuity Variance Systems to be developed following these visits.</p> <p><b>Progress: August 2011</b> <i>The General Manager of Secondary Services and the Director of Nursing, Midwifery and Allied Health visited Nelson and Southern District Health Boards to look at their Patient Acuity Variance Systems in May 2011. Recommendations to be developed.</i></p> <p><b>Progress: October 2011</b> <i>The review and establishment of an acuity tool at SCDHB has been placed on the SCDHB Safe Staffing and Healthy Workplace agenda (SSWP). This action is consistent with the approach that all DHBs are taking. SCDHB will be reviewing and engaging with any national acuity tool activity that matched SCDHB needs as they will arise from the SSHWP Unit of the DHB shared services previously known as DHBNZ. By taking this action SCDHB has addressed the concern raised in the 2009 certification audit as SCDHB is now assimilated the undertaking to review and establish within the MECA based commitment of the SSHWP group that has on its work plan the</i></p>	8 Aug 2011	Oct 2011	<p><b>29 August 2011</b> Action accepted. Please provide progress report and supporting evidence by 1<sup>st</sup> November 2011.</p> <p><b>15 November 2011</b> <b>Auditor Comment:</b> Action accepted. Progress update viewed. Please provide a further progress report on the development of a documented process to identify patient acuity variances, this could be in the form of a policy. Please provide by <u>8 February 2012.</u></p>

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1.2.8	1.2.8.1	PA Low	<p>Develop a documented process to identify patient acuity variances.</p> <p><b>Named Responsibility:</b> Director of Nursing, Midwifery and Allied Health / General Manager Secondary Services</p>	<p><i>assessment and recommendation of a suitable acuity tool to SCDHB.</i></p> <p><b>Progress: December 2011</b> <i>Budget request initiated. Business Case to be developed for validated acuity tool.</i></p>	8 Aug 2011	Oct 2011	

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1.3.6	1.3.6.1	PA Low	<p><b>Surgical:</b></p> <ol style="list-style-type: none"> <li>1. Complete the documentation of all risk assessments.</li> <li>2. Develop consistency in care planning documentation</li> </ol> <p><b>Named Responsibility:</b> Director of Nursing, Midwifery and Allied Health</p>	<p><b>Finding:</b></p> <ol style="list-style-type: none"> <li>1. Risk assessments are not completed for all patients (six out of eight files reviewed did not have falls or Waterlow risk assessments completed), as required by the SCDHB Clinical Documentation Standards, which state that falls and Waterlow assessments will be completed within 24 hours of admission. The one file with risk assessments completed did not define goals to manage the high level of risk identified.</li> <li>2. Not all files reviewed have a plan of care documented as required by the SCDHB Clinical Documentation Standards.</li> </ol> <p><b>Action Plan:</b></p> <p>The Admission to Transfer of Care Documentation Project was commenced in September 2010. Following an evaluation of the current assessment tools utilised in the DHB a new multidisciplinary documentation package is being developed. The documentation package is due to be piloted in the wards from June to September 2011. Evaluation to include facilitated feedback to project group and outcome measurement via Retrospective Chart Audit.</p> <p><b>Progress: August 2011</b> <i>A multidisciplinary documentation package has been developed which is currently in draft. The package is on track to be trialled in the wards in September 2011.</i></p> <p><b>Progress: December 2011</b> <i>Trial of multidisciplinary documentation complete. Evaluation of tool received from staff. Retrospective Chart Audit data utilised as outcome measure.</i></p>	8 Feb 2012		<p><b>29 August 2011</b></p> <p>Action Accepted. Please provide progress report and supporting evidence by <u>8 February 2012</u> (as per MOH Schedule)</p>

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1.3.6	1.3.6.4	PA Low	<p><b>Children:</b> Review best practice clinical guidelines, such as, sedation for imaging (using chloral hydrate) to ensure guidelines include risk management and monitoring.</p> <p><b>Named Responsibility:</b> Clinical Nurse Manager Paediatrics / Service Manager Medical Services</p>	<p>Finding: Not all paediatric nursing clinical policy documents outline actions to take in order to ensure clinical risks are managed and monitored occurs.</p> <p>Action Plan: 1. Review paediatric nursing clinical policies/protocols to ensure they meet best practice guidelines. To be completed by 1<sup>st</sup> May 2011. 2. Update polices/protocols to ensure that all clinical risks are managed and monitored.</p> <p><b>Progress: Aug 2011</b> <i>A review of paediatric nursing clinical policy/procedures against best practice guidelines was completed in May 2011. All policies/procedures identified as requiring additional information to ensure clinical risks are managed and monitored are to be updated by mid September 2011.</i></p> <p><b>Progress: October 2011</b> <i>Policy in draft, awaiting sign off.</i></p> <p><b>Progress: December 2011</b> <i>Policy signed off.</i></p>	8 Aug 2011	Dec 2011	<p><b>29 August 2011</b> Action Accepted. Please provide progress report by <u>8 February 2012</u></p>

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Std	Criteria	Rating	Corrective action Required (What is to be achieved)	Proposed Action (How it will be achieved)	By When	Actual	Auditor Response
1.3.6	1.3.6.4	PA Low	<p><b>Mental Health:</b> Review seclusion practice and alternatives to use of seclusion to ensure respectful service in accordance with current accepted good practice.</p> <p><b>Named Responsibility:</b> Clinical Nurse Manager Inpatient Unit / Service Manager Mental Health, Assessment, Treatment and Rehabilitation and Community Services</p>	<p><b>Finding:</b> Frequent use of seclusion, including lengthy periods of seclusion for individual patients, is not in line with current accepted good practice.</p> <p><b>Action Plan:</b></p> <ol style="list-style-type: none"> <li>1. Establish a Seclusion Review Group to review current practice against good practice guidelines and provide recommendations e.g. clinical guidelines, environmental changes.</li> <li>2. Analysis of utilisation of seclusion from the past three years. Continue to report on current utilisation.</li> <li>3. Establish a client working party to assist in the development and re-design of the ward environment.</li> </ol> <p><b>Progress: August 2011</b></p> <p><b><i>Seclusion Review Group established. Review of current practice against good practice guidelines completed with, recommendations provided.</i></b></p> <p><b><i>Analysis of utilisation of seclusion from the past three years completed. Current usage is reported to the Clinical Risk Management Committee on a monthly basis.</i></b></p> <p><b><i>Client working party established. List of recommendations developed. A number of recommendations have been implemented with the remaining recommendations forwarded to the Acute Mental Health Service Refurbishment Project Manager.</i></b></p>	8 Aug 2011	Aug 2011	<p><b>29 August 2011</b> Action Accepted. Please provide progress report by <u>8 February 2012</u>.</p>

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1.3.6	1.3.6.4	PA Low	<p><b>Mental Health:</b> Review seclusion practice and alternatives to use of seclusion to ensure respectful service in accordance with current accepted good practice.</p> <p><b>Named Responsibility:</b> Clinical Nurse Manager Inpatient Unit / Service Manager Mental Health, Assessment, Treatment and Rehabilitation and Community Services</p>	<p><i><b>A business case for the Acute Mental Health Service Refurbishment Project was received in August 2011. The business case includes an intensive care plan for clients requiring intensive care when admitted to the inpatient unit.</b></i></p> <p><b>Progress Report: December 2011</b></p> <p><i><b>Business Case for Acute Mental Health Service Refurbishment Project (in draft).</b></i></p> <p><i><b>Staff training session on Sensory Modulation was completed in November 2011.</b></i></p>			

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1.3.12	1.3.12.3	PA Mod	<p><b>Surgical:</b> Define competencies to assess staff ability to safely administer IV medications to paediatric patients.</p> <p><b>Named Responsibility:</b> Clinical Nurse Manager Paediatrics / Nurse Educator Staff Development Unit</p>	<p><b>Finding:</b> There are no competencies identified for the safe administration of intravenous medications to paediatric patients.</p> <p><b>Action Plan:</b> 1. Identify specific competencies required to safely administer IV medications to paediatric patients. 2. Develop an area specific assessment incorporating identified competencies to assess staff ability to safely administer IV medications to paediatric patients</p> <p><b>Progress: August 2011</b> <i>An area specific assessment process for safe administration of intravenous medications to neonatal and paediatric patients has been developed. The assessment process includes specific competencies which must be met for nursing staff to be endorsed to administer intravenous medications to neonatal and paediatric patients. The Neonatal and Paediatric Guideline will be located in the Intravenous and Related Therapy Resource Manual and the assessment will be completed by staff who administer IV fluid and medication to neonatal and paediatric patients. Audit tools to be utilised to evaluate process.</i></p>	8 Aug 2011	Aug 2011	<p><b>29 August 2011</b> Action Accepted. Please provide progress report and supporting evidence by <u>8 February 2012</u>.</p>

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1. Health and Disability Services (Core) Standards							
Std	Criteria	Rating	Corrective action Required (What is to be achieved)	Proposed Action (How it will be achieved)	By When	Actual	Auditor Response
1.3.12	1.3.12.3	PA Mod	<p><b>Surgical:</b> Define competencies to assess staff ability to safely administer IV medications to paediatric patients.</p> <p><b>Named Responsibility:</b> Clinical Nurse Manager Paediatrics / Nurse Educator Staff Development Unit</p>	<p><b>Progress: December 2011</b> <i>The Intravenous and Related Therapy Project is progressing. The resource manual which includes the Paediatric guideline is due to be distributed for wider consultation in early 2012. Audit tools to be developed and implemented in March 2012.</i></p>	8 Aug 2011	Aug 2011	

## CORRECTIVE ACTION PLAN

2. Health and Disability Service (Restraint Minimisation and Safe Practice) Standards							Auditor Response:
Std	Criteria	Rating	Corrective action Required (What is to be achieved)	Proposed Action (How it will be achieved)	By When	Actual	Auditor Response:
2.1.1	2.1.1.1	PA Low	<p>Categorise the use of lap belts as enablers in the restraint protocol.</p> <p><b>Named Responsibility:</b> Nurse Coordinator Quality and Risk</p>	<p><b>Finding:</b> An alteration to the restraint protocol is required to ensure that lap belt are correctly categorised as enablers.</p> <p><b>Action Plan:</b> Nurse Coordinator Quality &amp; Risk to update protocol to reflect lap belt correct categorisation as enabler.</p> <p><b>Progress: August 2011</b></p> <p><i>The Restraint Minimisation and Safe Practice Protocol is currently under review. The SCDHB policy and procedures cover inpatient, primary, community and aged care (certification audit was only concerned with the inpatient services). Therefore the lap belt will be to be categorised as an enabler within inpatient service but remain as an approved restraint device within Talbot Park Aged Care Facility (successful aged care certification audit 2009 and spot audit Feb 2011).</i></p>	8 Feb 2012		<p><b>29 August 2011</b> Action accepted. To be reviewed at next audit.</p>

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2. Health and Disability Service (Restraint Minimisation and Safe Practice) Standards							Auditor Response:
Std	Criteria	Rating	Corrective action Required (What is to be achieved)	Proposed Action (How it will be achieved)	By When	Actual	Auditor Response:
2.1.1	2.1.1.5	PA Low	<p>1. Ensure the attendance of all staff at restraint (NVCI) training, as required by the SCDHB restraint Policy</p> <p><b>Named Responsibility:</b> Clinical Nurse Managers</p> <p>2. Review the use of bed rails across the organisation and ensure staff understand their approved use.</p> <p><b>Named Responsibility:</b> Nurse Coordinator Quality and Risk / Nurse Educator – Clinical Staff Development Unit</p>	<p><b>Finding:</b> Some services have low rates of compliance with the NVCI course which provides de-escalation training. The use of bedrails in confused patients is associated with a high degree of risk for patient harm. The organisation needs to review this aspect of training and also review the use of bed rails across the organisation.</p> <p><b>Action Plan:</b></p> <ol style="list-style-type: none"> <li>1. Meet with Clinical Nurse Managers (CNMs) to discuss responsibility for them ensuring their staff attendance at NVCI. Report on increased attendance of staff at NVCI training and how CNM will maintain training.</li> <li>2. Meet with Clinical Nurse Educator/Manager Staff Development Unit to formulate action plan to review use of bedrails across clinical areas, gauge understanding of restraint policy / protocol in clinical areas.</li> <li>3. Use the knowledge and feedback gained to develop training on restraint, particularly use of bedrails.</li> <li>4. Update restraint questionnaire.</li> </ol> <p><b>Progress: August 2011</b></p> <p><i>Meeting with Clinical Nurse Managers has occurred and rates of compliance with NVCI training continue to improve.</i></p> <p><i>Restraint Minimisation and Safe Practice Procedures are currently under review, with changes being made in regard to bedrails. Clinical staff and the Staff Development Unit Manager have contributed to the review process. The restraint questionnaire will be updated in line with staff feedback and approved procedural changes.</i></p>	8 Feb 2012		<p><b>29 August 2011</b></p> <p>Action accepted. Please provide progress report and supporting evidence by <u>8 February 2012</u>.</p>

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2. Health and Disability Service (Restraint Minimisation and Safe Practice) Standards							
Std	Criteria	Rating	Corrective action Required (What is to be achieved)	Proposed Action (How it will be achieved)	By When	Actual	Auditor Response:
2.2.4	2.2.4.1	PA Low	<p>Review all episodes of restraint by police to ensure that evaluation of the restraints meets the requirements of the Standard.</p> <p><b>Named Responsibility:</b> Clinical Nurse Manager Emergency Department (CNM ED) / Nurse Coordinator Quality and Risk</p>	<p><b>Finding:</b> Evaluation of restraint is not carried out as per policy, which states that evaluation must occur after each episode of restraint. This does not occur after personal restraint by Police</p> <p><b>Action Plan:</b></p> <ol style="list-style-type: none"> <li>1. Meet with CNM ED to discuss action. Meet with CNM CCU/ICU to discuss action.</li> <li>2. Review of policy/protocol to ensure Q&amp;R ph/fax details have been updated.</li> <li>3. Education to staff regarding the policy requirements.</li> <li>4. Formulate process, in conjunction with CNM, to evaluate any restraint that takes place where police are involved.</li> <li>5. Update restraint questionnaire</li> </ol> <p><b>Progress: Aug 2011</b></p> <p><b>Meetings actioned with Clinical Nurse Managers and feedback received.</b></p> <p><b>Quality and Risk phone/fax details on restraint evaluation form are current. Forms are available to staff on Microsoft Outlook, public folders, clinical forms.</b></p> <p><b>The Restraint Minimisation and Safe Practice Procedure is currently under review. Evaluation of restraint process involving the police will be included in the update. There have been no reported incidents of personal restraint by police in the emergency department in the last six months.</b></p>	8 Aug 2011	Aug 2011	<p><b>29 August 2011</b></p> <p>Action accepted. Please provide progress report and supporting evidence by <u>8 February 2012</u>.</p>

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2. Health and Disability Service (Restraint Minimisation and Safe Practice) Standards								
Std	Criteria	Rating	Corrective action Required (What is to be achieved)	Proposed Action (How it will be achieved)	By When	Actual	Auditor Response:	
2.2.4	2.2.4.1	PA Low	<p>Review all episodes of restraint by police to ensure that evaluation of the restraints meets the requirements of the Standard.</p> <p><b>Named Responsibility:</b> Clinical Nurse Manager Emergency Department (CNM ED) / Nurse Coordinator Quality and Risk</p>	<p><b>Progress: December 2011</b></p> <p><i>The process for recording the incidence of restraint by Police has been via the incident management system. To date there have been no incidence of restraint by Police in the acute area since the last progress report.</i></p> <p><i>The updated procedure makes specific mention of restraint when Police are involved.</i></p>				