TALBOT PARK

SOUTH CANTERBURY DISTRICT HEALTH BOARD

CORRECTIVE ACTION PLAN

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

Timeline	**Report to DAA by**		
months	25th June 2011	Received:	
months	25th September 2011	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**
1.1.10	1.1.10.7	PA Mod	Ensure advance directives are valid and meet legislative requirements **Named Responsibility**: Penny Dewar	**Finding:** Not all signed advanced directives are valid. **Action Plan:** Review current protocol outlining steps to be taken Education for staff provided at RN/EN meeting Standard to be included in documentation/care plan audit **Progress Report: June 2011** Resuscitation Status protocol has been reviewed to meet legislative requirements. Resuscitation form has been updated to include annual review of status by the General Practitioner Had been discussed with RN/EN's at April and May staff meetings. Standard has been included in draft documentation/care plan audit. Audit results will be discussed at staff meetings. **Progress Report: September 2011** Resuscitation protocol will be reviewed again once SCDHB Withholding & withdrawing treatment policy has been updated. Section on memory will also be reviewed **Progress Report: December 2011** No further progress as awaiting SCDHB withdrawing and withholding policy to be updated	3 months 25th June 2011 December 2011 February 2012		**June 2011** Partially met. Provide copy of; Updated resuscitation protocol and form April & May meeting minutes showing discussion of updated protocol Care plan audit tool which shows inclusion of the standard as described **August 2011** Action met Recommendation that the resuscitation protocol be kept under review and the residents and GP's involvement in the decision to resuscitate or not are clearly understood. Also reference to memory is not generally made as this forms only ones part of determining whether a person is competent (of sound mind) or not

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12.2	1.12.2.2	PA Low	Evidence is required that the ARC contract includes an agreement to have more that 20 beds in the dementia wing **Named Responsibility**: J Power	**Finding:** The facility has 29 beds in the specialist dementia wing. The ARC contract states that dementia units are to accommodate no more than 20 beds, or any higher number as agreed to by both parities. There is no documentation available on the day of the audit to state an agreement for more than 20 residents in the dementia wing had been made. **Action Plan:** • Evidence to be provided of strategy, planning and accountability **Progress Report: September 2011** This information will be supplied directly to SISSAL by Jason Power, Portfolio Holder SCDHB	6 months 25th September 2011	Complete September 2011	**September 2011** Action met There is no further required action or recommendation in relation to this criterion

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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**
1.3.3	1.3.3.2	PA Mod	Evidence is required that residents and/or their familes, where appropriate, are involved in developing and reviewing the plan of care. **Named Responsibility**: R Craig CNM	**Finding:** There are no formal family or patient meetings to discuss and plan care. There is no documentation on care plans that resident and/or their families, where appropriate, have been consulted in planning and reviewing the care. **Action Plan:** Multidisciplinary care plan has been updated with a space for signatures to indicate that the resident and family have been involved in care planning. Standard to be included in documentation/care plan audit. **Progress Report: September 2011** Falls assessment tool is the tool used by the SCDHB. Talbot Park will review the Coombe Assessment falls risk assessment tool for use in Talbot Park **Progress Report: December 2011** Coombe Assessment falls risk tool has been reviewed and it has been decided to continue with SCDHB current tool so that consistency across the DHB is maintained. Documentation audits are being undertaken quarterly. Action plans are developed and discussed with staff at staff meetings At the 6 monthly review of the care plan, care is being discussed with family/whanau and documented.	3 months 25th June 2011	Complete August 2011	**June 2011** Partially med Further evidence A copy of the updated care plan showing resident or family input. A copy of the care plan audit tool (as for CAR#1) which shows inclusion of the standard **September 2011** Action met Recommendation That Talbot Park adopt the industry wide accepted current falls risk assessment tool known as the Coombe assessment

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1.3.6	1.3.6.1	PA Mod	Evidence is required that assessments are completed and that this information is transferred into the residents' care plans to ensure they received the interventions required Named Responsibility: R Craig CNM	**Finding:** Information from completed assessments is not always transferred into the care plans i.e. a resident identified as moderate falls risk did not have this documented in care plan. Weights were not documented in Otipua Wing for the month of January 2011. **Action Plan:** Standard to be included in documentation audit Results to be discussed at RN/EN meeting **Progress Report: June 2011** Increased space in multidisciplinary care plan in order that findings from assessment tools can be incorporated in the residents care plan. Standard included in documentation/care plan audit tool Documentation/care plan audit tool has been developed and will be trialled on 4 sets of notes in June with planned roll out for July 1 2011 Audit process has graphs and action plans which will be completed by Quality Facilitator in conjunction with CNM. Results will discussed at RN/EN and HA meetings **Progress Report: December 2011** • This action continues to be monitored through the documentation/care plan audit	3 months 25th June 2011	Complete August 2011	**June 2011** Partially met Further evidence • Copy of 3 amended care plans showing interventions based on assessment and with increased space as described • Copy of developed documentation/care plan audit tool • Copy of audit results referred to as occurring in June including action plans, that were presented at RN/EN and HA meeting **September 2011** Action met There is no further required action or recommendation in relation to this criterion

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1. Health and Disability Services (Core) Standards							
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1.3.7	1.3.7.1	PA Low	Each resident has an activities plan that includes goals that are regularly evaluated and is developed with the resident and, where appropriate, the family Named Responsibility: M Clarke DT	**Finding:** There is no documentation of family/resident involvement in the developing and planning of activities for each resident. The residents do not have individual goals for the activities they can participate in or would like to participate in, that are regularly evaluated. **Action Plan:** Activities plan documentation to be developed Activities plan to be kept in client file with care plan **Progress Report: June 2011** An activities plan has been developed by the Registered Diversional Therapist The plan is currently being trialled in Hospital level dementia wing. **Progress Report: September 2011** Diversional therapy activities plan report submitted Copies of 4 diversional activities plan submitted **Progress Report: December 2011** • All residents in the facility now have activity plans	6 months 25th September 2011	**Complete Septembe r 2011**	**June 2011** **Partially meet** **Further evidence** **A copy of 3 current activity plans showing input form resident and where appropriate the family that include regular evaluation of goal achievement** **September 2011** **Action met** **There is no further required action or recommendation in relation to this criterion**

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1.3.8	1.3.8.1	PA Mod	Evaluations are conducted at a frequency that enables regular monitoring of progress towards achievement of desired outcomes **Named Responsibility**: R Craig CNM	**Finding:** It was identified that some care plans when reviewed are signed by a RN on the front of the care plan. There are up to ten different sections/needs that are in the care plan and these are not always signed off by a RN. It is not clear if all the needs of each resident have been reviewed by a RN as required **Action Plan:** Standard to be included in documentation audit Results to be discussed at RN/EN meeting Protocol to be developed on patient reviews Nursing care plan documentation protocol to be reviewed Monitor compliance to existing and new protocols **Progress Report: September 2011** Standard has been included in the documentation audit Protocols have not yet been reviewed 3 care plans showing residents assessed needs and outcomes are evaluated are attached **Progress Report: December 2011** • This action continues to be monitored through the documentation/care plan audit		Complete September 2011	**June 2011** Partially met Further evidence Copies of 3 care plans showing that residents assessed needs and desired outcomes are evaluated as required and that this is clearly documented **September 2011** Action met There is no further required action or recommendation in relation to this criterion

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<table>
<tr><th colspan="7">1. Health and Disability Services (Core) Standards</th><th></th></tr>
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<tr><td>1.3.12</td><td>1.3.12.1</td><td>PA Mod</td><td>Medicine reconcilliation processes be implemented and documents accordingly

Named Responsibility:
N Rowbottom Pharmacist</td><td>Finding: The pharmacist does not undertake three monthly medicine reconciliations and no documented reconciliations are available.
Action Plan:
• Quarterly Audits to be undertaken as per protocol by Talbot Park Pharmacist
• Review current protocol
• Audit tool to be developed

Progress Report: June 2011
All new admissions have medication charts faxed to the pharmacist
On admission, the Talbot Park Medication chart is checked against Discharge summary.
Pharmacist is to review all medication processes at Talbot Park. From this review protocols and processes will be developed
Has not progressed as planned as Pharmacist unavailable due to personal circumstances

Progress Report: September 2011
Meeting has been held with Pharmacist to discuss processes at Talbot Park
Talbot Park Medication protocols are being reviewed utilising the Ministry of Health's standard for management of medication. Will be sent to SCDHB Pharmacist for review and comment.
On admission/readmission to Talbot Park the resident prescription is checked against Discharge summary. Any anomalies are notified via fax to the GP.(see attached copy)</td><td>3 months 25th June 2011

Deferred until September 2011

December 2011</td><td></td><td>June 2011
Partially met
Further evidence
• Copies of documented 3 monthly medicine reconciliations
• Talbot Park to review medication management processes and supply a copy of the updated protocol
Recommendation
Talbot Park utilise the MOH revised standard for management of medication available on their website
September 2011
Remains partially met</td></tr>
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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 (cont)	1.3.12.1	PA Mod	Medicine reconcilliation processes be implemented and documents accordingly **Named Responsibility**: N Rowbottom Pharmacist	**Progress Report: November 2011** • Review of our documentation showed that admission documentation did not allow staff to document that medicine reconciliation had occurred on admission or transfer to our facility. We have updated our documentation and this is attached. • We are still working with the SCDHB pharmacist to review our medicines management system. We are planning an extensive review which will include medication management, supply & receipt of Nomads, reconciliation, 3 monthly reviews and stock audit. Therefore we would like to request an extension this until February 2012 **Progress Report: December 2011** • Review of all medication protocols has commenced	February 2012		

CORRECTIVE ACTION PLAN

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:**
2.1.1	2.1.1.2	PA Low	Ensure the care plans are congruent with the restraint and enabler policy and procedure **Named Responsibility:** P Dewar Quality Facilitator	**Finding:** One resident in the hospital wing has a signed a consent for an enabler in the form of a bedrail. It is listed in her care plan as an enabler. The mobility section has been signed by the GP and ticked as the resident needing restraint in the form of bed rails. **Action Plan:** Staff Education on restraint documentation Review/update restraint register Standard to be included in documentation audit **Progress Report: September 2011** Restraint audit was undertaken in August 2011 copy of results attached). Action plan being developed from these results Annual staff restraint questionnaire is due to be undertaken in December 2011 (audit calendar attached and copy of SCDHB questionnaire) Definition of enabler/restraint used in Talbot Park (attached) Currently we have one resident who is consented for use of an enabler (copy attached). All other residents on the restraint register are consented for restraint. **Progress Report: December 2011** Quarterly restraint audits are being undertaken and results discussed with staff • This action continues to be monitored through the documentation/care plan audit	6 months 25th Septemb er 2011	Complete Septemb er 2011	**September 2011** Action met There is no further required action or recommendation in relation to this criterion

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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:**
2.1.1	2.1.1.5	PA Mod	All staff, employed and contracted, and who have contact with residents, undergo appropriate restraint prevention and de-escalation education to ensure safety for all **Named Responsibility:** L Alexander Nurse Manager	**Finding:** Not all staff are adequately educated to deal with a potentially difficult situation where restraint prevention and de-escalation techniques maybe required. **Action Plan:** All staff employed receive NVCI training 5 staff per month are rostered to attend NVCI update training All staff employed by SCDHB receive NVCI training every 3 years Spotless contractor staff member in Dementia Unit has received NVCI training Discuss NVCI training with Spotless Services **Progress Report: June 2011** Spotless staff member in Watlington Wing has received NVCI training Discussed with staff that if a situation occurs to seek help from the registered nurse on duty Staffs employed by SCDHB receive NVCI training every 3 years. **Progress Report: September 2011** All staff attend NVCI training within 3 months of commencing employment **Progress Report: November 2011** NVCI training is now being provided on site by a staff member who is NVCI trained. A new protocol for NVCI training has been developed to reflect this. Attached documents • Master training register • List of staff who are booked/attended sessions • Copy of letters now sent to staff • NVCI training protocol **Progress Report: December 2011** • Fortnightly training sessions are being held on site for staff	3 months 25th June 2011	Complete September 2011	**June 2011** Partially met Further evidence LA table showing the total roll of employees who are required to attend NVCI training table to indicate training attendance list where current and due date for next attendance Copy of induction pack for all new staff **September 2011** The altered plan for ensuring that NVCI training is achieved by all relevant staff and least every 3 years **November 2011** The dates for the planned training sessions are to be advised and if already passed, staff attendance records are to be supplied as evidence

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<tr><th colspan="7">2. Health and Disability Service (Restraint Minimisation and Safe Practice) Standards</th><th></th></tr>
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<tr><td>3.5</td><td>3.5.7</td><td>PA Low</td><td>The results of infection prevention and control surveillance data, conclusions and any recommendations to help achieve a reduction in infections are documented, acted upon, evaluated and reported back to staff at Talbot Park

Named Responsibility: M Jones IC Nurse</td><td>Finding: The staff at Talbot hospital send a notification of each patient who develops an infection to the infection control nurse at South Canterbury DHB. In the past these statistics are collated and analysed and sent back to Talbot. In 2010/11 there has been no collation or analysis of these statistics sent back from SCDHB to Talbot
Action Plan:
Monthly Infection control surveillance reports received from Infection control including conclusions and recommendations
Infection control reports discussed and actioned at Operational meetings
Internal audit to be developed for infection control surveillance
Progress Report: June 2011
• Initial discussions have been held with Infection control to look at developing a process to receive the infection control surveillance reports, no decision made.
• Decision to collect/collate data independent of the Infection Control Nurse. Data will be presented to the Talbot Park infection control committee and RN/EN at monthly staff meetings. This information will be sent to the IC Nurse
Progress Report: September 2011
• Data collection form has been reviewed
• Data is being collected and collated by Quality facilitator as well as being sent through to the infection control nurse
• Results are displayed for staff and will be discussed at Bi monthly infection control meetings and Registered & Enrolled Nurses meeting
• Infection control programme for 2011 to be reviewed by Talbot Park infection control committee in September 2011
Progress Report: December 2011
• Infection Control programme agreed to be Infection control committee
Benchmarking of data with other Aged Care facilities to commence in 2012</td><td>6 months 25th

Septemb er 2011</td><td>complete Septemb er 2011</td><td>June 2011
Partially met
Further evidence
Copy of 3 monthly infection control surveillance report
Minutes of Operational meeting where infection control report discussed/actioned

September 2011
Action met
There is no further required action or recommendation in relation to this criterion</td></tr>
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