**Presbyterian Support Central - Kandahar**

**Current Status:** **17-Sep-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.**

**General overview**

Kandahar Home provides rest home, medical and hospital level care for up to 63 residents. There were 23 hospital and 26 rest home level care beds occupied at the time of audit. Kandahar Court provides specialist dementia level care for up to 37 residents. Occupancy on the day of audit was 29 residents.

There is a facility manager (non-clinical) who has been in the role since November 2012. He is supported by a care manager (registered nurse) at Kandahar Home and a care manager (registered nurse) at Kandahar Court. The manager is also supported by a regional manager and an experienced support team at Presbyterian Support Central based in Wellington. There is currently one complaint being investigated by the Health and Disability Commission.

The previous shortfalls identified in the previous audit around care planning, assessment processes, and aspects of medication practices have been addressed. However there continues to be an improvement required around appraisals.

This audit also identified improvements required around medication management and aspects of care planning.

**Audit Summary AS AT** **17-Sep-13**

Standards have been assessed and summarised below:

**Key**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

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| **Consumer Rights** | Day of Audit  17-Sep-13 | Assessment |
| 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. |  | **Standards applicable to this service fully attained** |

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| --- | --- | --- |
| **Organisational Management** | Day of Audit  17-Sep-13 | Assessment |
| 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 low risk** |

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| **Continuum of Service Delivery** | Day of Audit  17-Sep-13 | Assessment |
| 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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| **Safe and Appropriate Environment** | Day of Audit  17-Sep-13 | Assessment |
| 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. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  17-Sep-13 | Assessment |
| 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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| **Infection Prevention and Control** | Day of Audit  17-Sep-13 | Assessment |
| 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** |

**Kandahar Home**

Presbyterian Support Central

Surveillance audit - Audit Report

Audit Date: 17-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Presbyterian Support Central |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Kandahar Home | 8 Roberts Road |  | Masterton |
| Kandahar Court | 2 Colombo Road | Lansdowne | Masterton |

|  |
| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
|  |

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 17-Sep-13 **End Date:** 17-Sep-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXXX | RN, Auditor certificate | 9.00 | 6.00 | 17-Sept-13 |
| Auditor 1 | XXXXXXXX | RN, Auditor certificate | 9.00 | 5.00 | 17-Sept-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX |  |  | 2.00 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 18.00 | **Total Audit Hours off site** *(system generated)* | 13.00 | **Total Audit Hours** | 31.00 |
| **Staff Records Reviewed** | 9 of 120 | **Client Records Reviewed** *(numeric)* | 11 of 78 | **Number of Client Records Reviewed using Tracer Methodology** | 3of 11 |
| **Staff Interviewed** | 11 of 120 | **Management Interviewed** *(numeric)* | 2 of 5 | **Relatives Interviewed** *(numeric)* | 4 |
| **Consumers Interviewed** | 8 of 78 | **Number of Medication Records Reviewed** | 22 of 78 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

I, (full name of agent or employee of the company) XXXXXXXX (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofHealth and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health and Disability Auditing New Zealand Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 5 day of November 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit: 🗷

The audit summary has been developed in consultation with the provider: 🗷

Electronic Sign Off from a DAA delegated authority (*click here*): 🗷

# Services and Capacity

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Kandahar Home | 63 | 49 | 20 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Kandahar Court | 37 | 29 | 0 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Kandahar Home provides rest home, medical and hospital level care for up to 63 residents. There were 23 hospital and 26 rest home level care beds occupied at the time of audit. Kandahar Court provides specialist dementia level care for up to 37 residents. Occupancy on the day of audit was 29 residents.

There is a facility manager (non-clinical) who has been in the role since November 2012. He is supported by a care manager (registered nurse) at Kandahar Home and a care manager (registered nurse) at Kandahar Court. The manager is also supported by a regional manager and an experienced support team at Presbyterian Support Central based in Wellington. There is currently one complaint being investigated by the Health and Disability Commission.

The previous shortfalls identified in the previous audit around care planning, assessment processes, and aspects of medication practices have been addressed. However there continues to be an improvement required around appraisals.   
This audit also identified improvements required around medication management and aspects of care planning.

1.1 Consumer Rights

There is an open disclosure policy which describes ways that information is provided to residents and families/representatives at entry to the service continually and as required. Family are involved in the initial care planning and receive and provide on-going feedback. Regular contact is maintained with family including if an incident/ accident or a change in residents health status occurs. The service has documented complaints and there is evidence of follow up. The complaints register reviewed included verbal and written complaints. There is one complaint being investigated by the Health and Disability Commission.

1.2 Organisational Management

Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and QPS benchmarking programme that is being implemented at PSC Kandahar Home and Kandahar Court. Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards and repairs to the building and grounds. There is a monthly quality committee meeting that includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. There are also monthly staff meetings, resident meetings and six monthly family meetings.

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff state that there are sufficient staff on duty at all times. There is a continued improvement required around the completion of staff appraisals.

There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

1.3 Continuum of Service Delivery

The Registered nurse is responsible for each stage of service provision. The support plans and evaluations are reviewed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provide evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. There is evidence in the resident files that there is resident and/or family/whanau and multidisciplinary team input into the three monthly reviews. There is an improvement required around the documentation of interventions and management for short term problems where the residents goals or needs are unable to be met.

Education and medicines competencies are completed by all staff responsible for administration of medicines. All medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification and special instructions for administration. There are improvements required to aspects of medicine management.

Food services and all meals are provided from the kitchen on site at Kandahar Home and Hospital and Kandahar Court. Residents individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene. Extra snacks and beverages are available over a 24 hour period.

The recreation team leader and recreational officer plan an activity programme for the residents in Kandahar Home and Kandahar Court. The programme is varied, interesting and meets the recreational, physical, cognitive, cultural and spiritual needs and preferences of the consumer groups. The service now offers activities seven days per week in each facility.

1.4 Safe and Appropriate Environment

PSC Kandahar Rest Home and Kandahar Court dementia care are in separate buildings. Both buildings hold a current building warrant of fitness. Kandahar Court have relocated the entrance to the building since the previous audit to a more central position off the car park.

2 Restraint Minimisation and Safe Practice

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint were to be needed. Resident files sampled have detailed plans around the management of behaviours that challenge. There are currently five residents using enablers in Kandahar Home and three residents requiring the use of an enabler in Kandahar Court. Assessments and three monthly reviews for the continued need for an enabler have been conducted.

3. Infection Prevention and Control

Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control coordinator (a registered nurse) take overall responsibility for ensuring that the surveillance programme is well implemented with review trends and implementation of any recommendations. The service uses the QPS benchmarking programme for infection control.

All surveillance activities are the responsibility of the infection control coordinator with assistance from the quality committee through the monthly quality meeting. There is an online infection register in which all infections are documented monthly.

Summary of Attainment

* 1. Consumer Rights

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |  | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:10 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:0 FA:4 PA:0 UA:0 NA: 0 |

* 1. Organisational Management

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | PA Low | 0 | 3 | 1 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:2 CI:0 FA: 4 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:16 PA:1 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | PA Moderate | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Moderate | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:6 CI:0 FA: 4 PA Neg: 0 PA Low: 0 PA Mod: 2 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:0 FA:12 PA:2 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:7 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:3 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |  | 0 | 0 | 0 | 0 | 0 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 5 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 21): CI:0 FA:1 PA:0 UA:0 NA: 0 |

1. Infection Prevention and Control

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |  | 0 | 0 | 0 | 0 | 0 | 5 |

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| Infection Prevention and Control Standards (of 5): N/A: 4 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 29): CI:0 FA:2 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 34 **CI:** 0 **FA:** 13 **PA Neg:** 0 **PA Low:** 1 **PA Mod:** 2 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 0 **FA:** 38 **PA:** 3 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Presbyterian Support Central

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:17-Sep-13 End Date: 17-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.2.7 | 1.2.7.2 | PA  Low | **Finding:**  Staff appraisals were not current in two of nine staff files reviewed. (One was for a care manager and the other for the clinical leader). Appraisals were due to be completed in February 2013. The timely completion of staff appraisals was identified as a finding at certification audit and remains unresolved.  **Action:**  Ensure staff have current appraisals. | 3 months |
| 1.3.6 | 1.3.6.1 | PA  Moderate | **Finding:**  (i) Care plan reviewed of a hospital resident does not document that the resident has a chronic wound that is currently being treated. (ii) Escalating behaviour assessments have not been completed for two rest home residents with new/escalating behaviours. (iii) There are no short term care plans describing interventions and strategies for the management of specific behaviours. (iv) Two residents with weight loss (one hospital and one dementia care) do not have a short term support plan in place for the management of weight loss. (v) There is no weight loss monitoring in place for the resident in the dementia care unit.  **Action:**  i) Ensure chronic wounds are linked to the long term support plan. ii) Escalating behavioural assessments and short term support plans are to be completed for new/escalating behaviours iii) Ensure short term support plans and monitoring is in place for resident with weight loss. | 1 month |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.12 | 1.3.12.1 | PA  Moderate | **Finding:**  (i) Three of six medication charts reviewed in the hospital did not have allergies or no known allergies recorded on the medication charts. (ii) There are two medication charts in the dementia unit that have not been reviewed by a GP in the last three months, (iii) One telephone order in the dementia unit did not document the dose or frequency of the medication to be taken. Telephone orders are written on differing forms (medication drug chart in the hospital and medication alert form in the dementia care unit). There is no continuity of medication practice for telephone orders.  **Action:**  i) Ensure allergies/nil known allergies is documented on each resident medication chart. (ii) Ensure medication charts are reviewed at least three monthly by the GP, iii) Ensure the receiving and documenting of telephone orders follows medication policy. | immediately - 1 month |

# Continuous Improvement (CI) Report

Provider Name: Presbyterian Support Central

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:17-Sep-13 End Date: 17-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

**1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS**

**OUTCOME 1.1 CONSUMER RIGHTS**

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

**STANDARD 1.1.9 Communication**

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Discussions with eight residents (four hospital and four rest home) and four family members all stated they were welcomed on entry and were given time and explanation about services. Resident meetings occur monthly and relatives meetings occur three monthly. (Minutes of meetings sighted).

Family members, staff and residents interviewed state the manager and has an open-door policy is approachable.

A review of incident forms from September 2013 identified that relatives are informed in all cases where appropriate.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.

D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b Four family members (one rest home, one hospital and two dementia) interviewed stated that they are informed when their family members health status changes.

D 13.3 Eleven files reviewed included completed admission agreements.

Residents and relatives interviewed confirmed the admission process and agreement were discussed with them and they were provided with adequate information on entry.

D11.3 The information pack is available in large print and advised that this can be read to residents.

The service has policies and procedures available for access to interpreter services and residents (and their family/whānau) are provided with this information in resident information packs.

E4.1biii.There is written information on the service philosophy and practices particular to the Kandahar Court (dementia unit) included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

The residents and relatives survey conducted in 2012 evidenced overall resident satisfaction with the service. Areas for improvement identified from the resident survey have been implemented and evaluated.

**Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service has a clearly documented process for making complaints and this is communicated to residents/family/whānau. There is a copy of the process documented on the notice-board at the main entrance to Kandahar Home and also at Kandahar Court. Documentation including follow up letters and resolution demonstrates that complaints are well managed. Verbal complaints are also included and actions and response are documented. Discussion with eight residents and four relatives confirmed they were provided with information on complaints and complaints forms and one family member described having a concern addressed and resolution of the complaint has been achieved. Complaint forms were visible for residents/relatives in various places around the facility.

D13.3h. A complaints procedure is provided to residents within the information pack at entry.

There is a complaints folder and register that includes complaints verbal and written and includes sign-off. All complaints formal and informal are included on the complaints register and the PSC templates are used.

The complaints folder and register has been kept up to date and all complaints are included on the register with evidence of follow up and resolution.

There have been six complaints received to date in 2013. These six complaints were reviewed. All complaints were well documented including investigation, follow up, feedback (verbal, letter) and resolution. A letter from HDC dated 15-Feb-13 regarding one complaint was sighted requesting a response to a complaint made on 25-Jan-13. This documentation and response was evidenced to have been forwarded to HDC.

A complaint received in March 2013 regarding patient care (resident toe nails not cut for several months) resulted in the following corrective actions being implemented by the service; A contract was developed for the podiatrist containing a clear job description and responsibilities, an improved identification process of residents requiring podiatry treatment with improved communication between RNs and podiatrist and vice versa has been established, the development and implementation of a comprehensive hand over sheet for each shift with all residents being allocated a key worker, the dementia unit has reviewed it's acceptance and decline of entry to the service of residents identified with increased challenging behaviours and reflection of practice by RNs and ENs has been completed.

**Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

**STANDARD 1.2.1 Governance**

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Kandahar Home and Kandahar Court are part of the Presbyterian Support Central organisation. Kandahar Home and Kandahar Court are two separate sites. Kandahar Home provides rest home, medical and hospital level care for up to 63 residents. There were 23 hospital and 26 rest home level care beds occupied at the time of audit. There were no residents receiving care under medical contract.

Kandahar Court provides specialist dementia level care for up to 37 residents. Occupancy on the day of audit was 29 residents.

The service has well established quality and risk management systems. The organisation has committed resources and has available a quality coordinator and management are supported by a regional manager, a quality team leader, a clinical and professional educator and a clinical director.

The clinical director was visiting on site on the day of audit.

PSC Kandahar Home and Court have a documented mission statement, vision, values, corporate commitment and older person’s services goals.

There is a local risk management plan for 2013.

There is an Enliven PSC Kandahar Home and Court business plan that provides a mission, vision and values and goals. An action plan has been implemented to meet those goals.

The service has a structure that supports the continuity of management and quality of care and support (including staff management).

The manager who has been in the management position since November 2012 is non-clinical and is supported by two care managers (RNs) one in Kandahar Court and one in Kandahar Home, a quality coordinator and a clinical leader at Kandahar Home and regional manager.

The two care managers and quality coordinator were not available on the day of audit as they were attending education seminars. The clinical lead was in charge of clinical care in the Kandahar home and a registered nurse was covering in the absence of the care manager at Kandahar Court.

PSC provides care manager orientation training and support at least every two months across the organisation. Enliven also provides a two day education seminar annually for all care managers to ensure that all care managers receive at least eight hours annual professional development activities related to overseeing clinical care.

ARC,D17.3di (rest home), D17.4b (hospital), the manager and care managers have maintained at least eight hours annually of professional development activities related to managing a hospital.

**Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🗷 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The service has a current business and a quality and risk management plan for 2013 -14.

The service has continued implementing their quality and risk management system since previous certification and a number of quality improvements have occurred to address shortcomings in previous certification audit.

Presbyterian Support Services Central has an overall Quality Monitoring Programme (QMP) that is part of the quality programme and QPS benchmarking programme that is being implemented at PSC Kandahar Home and Kandahar Court. There has been a review of the Quality Monitoring Programme with new draft audit templates introduced. The new templates have been in use since January 2013.

The manager provides a balanced scorecard report to central office.

All staff are involved in quality improvements. The quality committee includes key staff from all areas of the service. Quality reports are provided to the committee by members of the quality committee and include (but not limited to); a) quality coordinators report, b) kitchen monthly report, c) health & safety monthly report, d) laundry monthly report, e) IC monthly report, f) restraint monthly report, g) clinical monthly report, h) managers monthly report, i) chaplains monthly report, j) activities monthly report, k) education monthly report, l) Eden monthly report, m) domestic/cleaning monthly report and n) administrative monthly report.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.

The Quality Monitoring Programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service’s on-going progress around quality improvement.

The service completes quarterly reports of the IC programme and the H&S programme to PSC Quality Coordinator.

The internal audit schedule has been combined to include QMP and QPS monitoring.

Policies and procedures cross-reference other policies and appropriate standards.

There is an organisation policy review group that has terms of reference and follows a monthly policy review schedule

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There is a comprehensive IC Manual. Restraint policy and Health &Safety policy/procedures.

There is an annual staff training programme that is implemented and based around policies and procedures, records of staff attendance and content has improved and sessions evaluated.

There is a policy review date schedule, and terms of reference for the policy review group.

New/updated policies/procedures are included in the "What’s New" manual for staff.

a) Monthly accident/incident/near miss reports are completed by the health and safety officer for each site that breaks down the data collected across the facility and staff incidents and accidents. These are also compared with the last month. The monthly reports provided to staff via meetings and staff notice boards include the QPS benchmarking indicator results that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents. There is a new online database for recording accidents and incidents with medication errors reported separately.

Incidents and accidents are also reported to PSC clinical director monthly.

b) The service has linked the complaints process with its quality management system. This occurs through the QPS benchmarking programme and the identification of complaints against a benchmark of the service peers. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Monthly manager reports include compliments and complaints.

c) There is an IC online register in which all infections are documented monthly. A monthly IC report is completed and provided to quality meeting. The service utilises the QPS benchmarking programme which analyses service data on a quarterly basis. Infections are also being documented on the newly introduced electronic database.

QPS data analysis includes: Competency testing for IC, Wound Infection Rate, skin infection rate, Infection rate, UTI’s, Respiratory Tract Infections, ENT rates and GI rates graphed quarterly. A benchmarking report from the 3 month data is prepared for staff and displayed on notice boards. Internal infection control audits are planned and undertaken during the year.

d) Health and safety monthly reports are completed for each service and presented to the quality committee and a quarterly health and safety report is also completed. The report includes identification of hazards and accident/incident reporting and trends are identified.

e) The PSC restraint approval group meets six monthly and includes a comprehensive review. Restraint internal audits are completed six monthly. PSC Kandahar Home and Kandahar Court are currently restraint free.

The service completes an internal audit for each area which results in a report that identifies criteria covered and achievement, a general summary of the audit results, key issues for improvement and an action plan for resolution. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness.

The service benchmarking programme identifies keys areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.

A hazard register is established for each site that includes a hazard register for all areas of the facilities. There is also an implemented hazard monitoring form that is implemented for environmental inspections.

Civil defence procedures are in place and supported by staff training.

Preventative maintenance audit is completed annually. There is a facility risk management plan 2013

The service documents risk or areas of concern and remedial action is identified as a result.

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident an hazard management

D19.2g Falls prevention strategies are in place such as falls risk assessment, physiotherapy assessment, low-low beds, sensor mats, landing mats, exercise classes to promote balance and range of movement and walking aids.

**Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.**

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:**

(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;

(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services.

Thirteen incident forms for September 2013 were reviewed for Kandahar Home and all show the form has been fully completed and reviewed by a registered nurse.

Incidents included three skin tears, three challenging behaviours, one resident found on floor, three falls, one resident found smoking in her room, and one report of bruising, one near miss (fall).

Kandahar Court, 20 incident forms were reviewed which included fourteen falls, five falls were related to one residents, three challenging behaviours, and three skin tears.

Resident experiencing frequent falls had had a recent review of medication completed by the GP and falls prevention management interventions were documented in the resident's care plan.

All incident forms from both facilities evidence on-going review and where appropriate actions to prevent recurrence completed by the care manager. Clinical meetings evidenced discussion around falls management and preventative measures to be implemented.

Quality meeting minutes include a comprehensive analysis of incident and accident data and analysis. A monthly incident accident report is completed which includes an analysis of data collected.

The monthly reports provided to staff via meetings and staff notice boards include the QPS benchmarking indicator results that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents.

D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

D19.3c Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.

An email from PSC Clinical Director to WDHB dated 23-Aug-13 advising of a medication error which had occurred was sighted. The GP had discontinued a resident’s prescribed warfarin dose on the residents medication chart. Blister packs sent from pharmacy contained warfarin therefore the RNs and ENs administering medications were removing the warfarin from blister packs and placing them in pharmacy returns box.

The GP had unknown to the service contacted pharmacy and recommenced the warfarin dose without informing staff or forwarding a prescription for the medication. Therefore the resident had not received warfarin dose.

PSC clinical director advised that an investigation was completed regarding the incident. Following this investigation a meeting with the GP and pharmacist has been arranged.

Education on medication administration has been conducted for all staff who administer medications. The clinical director advises that she will report findings from investigation and meeting with GP and pharmacist to the DHB.

**Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.4.3 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity.

A copy of practising certificates including RNs, EN's, pharmacists, the dietitian, the physiotherapist and GPs are kept.

There is a physiotherapist contracted to work 4 hours per fortnight.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Nine staff files were reviewed (one recreation officer, one cook, two registered nurses, one care manager, one clinical leader, and four health care assistants). Each folder had a file checklist and documentation arranged under personal information, correspondence, agreement, education and appraisals.

The previous certification audit identified that an improvement was required around staff appraisals being current. This remains an area for improvement.

The manager advised that currently the facility is actively recruiting for health care assistants. Agency staff cover these vacancies at present until the positions are filled.

Agency staff complete an orientation.

A comprehensive orientation programme is in place that provides new staff with relevant for safe work practice. This was described by staff and records are kept. A buddy system supports new staff.

There are two comprehensive orientation books that include checklists for completion in files reviewed. There is an implemented specific RN orientation book. Registered nurses complete a four week orientation programme and health care assistants are buddied up with a more senior health care assistant for one week’s orientation.

The RN interviewed at Kandahar Court has been with the service for two weeks. The RN has previous experience of working in aged care facilities. The RN described being buddied up with the care manager for orientation and continues to have on-going support.

There is a documented in-service programme for education and a specific staff educator. Competencies are identified and completed.

Health care assistants are encouraged and supported to undertake external education. Career force training is supported. The organisations policy is that after three months of employment all caregivers must be enrolled in Career force.

D17.8 Eight hours of staff development or in-service education has been provided annually. The organisation has a training framework for registered staff and another for health care assistants/caregivers. PSC Kandahar Home and Court has provided health care assistant and RN/EN compulsory training according to the framework.

Monthly reporting of training completed and percentages of staff attending is reported to the regional manager and clinical director monthly.

E4.5f There are 23 caregivers in total who work in the dementia unit (Kandahar Court). Eighteen have completed the required dementia standards and two are in the process of completing the standards.

Three staff have not yet completed the required dementia unit standards. All three staff members staff are enrolled but have yet to start the dementia education programme as they have recently been employed.

**Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Six of nine staff files reviewed evidenced staff appraisals were current. One staff member was recently employed and therefore annual appraisal was not yet due.

**Finding Statement**

Staff appraisals were not current in two of nine staff files reviewed. (One was for a care manager and the other for the clinical leader). Appraisals were due to be completed in February 2013. The timely completion of staff appraisals was identified as a finding at certification audit and remains unresolved.

**Corrective Action Required:**

Ensure staff have current appraisals.

**Timeframe:**

3 months

**Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Staff requirements are determined using an organisation service level/skill mix process and documented. Staffing levels are benchmarked against other PSC facilities. Staff levels/skill mix are meeting contract and industry norm requirements.

New staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. The QPS benchmarking quarterly report states that staff hours remain consistently above the mean.

The Manager works Monday-Friday 08.00-17.00 plus on call weekdays out of hours. There is an on call roster for weekends covered by the manager, two care managers and clinical lead who are each on call one weekend in four. The manager refers any clinical queries to the care manager on call. The care managers (one at Kandahar Home and Hospital and one at Kandahar Court are also on call for their respective areas on weekdays out of hours.

Staff interviewed reported that staffing levels were sufficient, however with the mix in care levels of hospital and rest home at Kandahar Home staff reported that it can mean that extra staffing hours are needed at times to provide the level of care required. Advised by the manager that the roster is able to be changed in response to resident acuity. Rosters reviewed evidence that rosters are flexible to allow extra staffing hours when there is an increase in resident needs.

**Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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.

**STANDARD 1.3.3 Service Provision Requirements**

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

D16.2, 3, 4: The 11 files reviewed (three hospital, four rest home and four dementia care), identified that in all 11 files an assessment was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plan were reviewed by a RN. There is documented evidence of resident/family/whanau participate in the care planning process. This is an improvement implemented from previous audit. All 11 long term care plans evidenced evaluations completed at least six monthly.

A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to);

a) nutritional and fluid assessment b) falls risk c) moving and handling assessment. d) Braden pressure area risk assessment, e) continence and bowel assessment f) pain assessment and Wong Baker face scale g) wound assessment h) behavioural assessment .

The service has access to community nursing and support services including continence nurse, wound care nurse, physiotherapist, podiatrist, speech language therapist, hospice and mental health team. Allied health professionals maintain progress notes in the resident file. The palliative care nurse visited a resident for a follow up visit on the day of audit.

D16.5e: 11 resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly. The RN interviewed stated the homes have a house GP. The GP or Nurse Practitioner visits weekly. The GP is available by mobile after hours. There is also an afterhours call centre with GP available 24/7.

Tracer Methodology :Hospital resident

*XXXXXX This information has been deleted as it is specific to the health care of a resident.*

Tracer Methodology: Rest home resident

*XXXXXX This information has been deleted as it is specific to the health care of a resident.*

Tracer Methodology: Dementia care resident

*XXXXXX This information has been deleted as it is specific to the health care of a resident.*

**Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Moderate

When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist nurse consultation. The RN and healthcare assistants interviewed stated that they have all the equipment referred to in support plans necessary to provide care, including hoist, chair scales, pressure relieving cushions, shower chairs, transfer belts, slippery sams, wheelchairs, gloves, aprons and masks.

D18.3 and 4 All staff report that there are adequate continence supplies and dressing supplies.

Continence products are available and resident files include a 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. Continence management in-services have been provided.

Complex or chronic wound assessment includes contributing health factors, allergies, nutritional status, length of time wound present, blood supply, any infection/systemic infection, malignancy, smoker, sleep disturbance and any diabetes. Wound progress notes and chronic wound support plans are in place for chronic wounds. Short term support plans are used for minor wounds and skin tears. The RN assesses all wounds and documents dressing changes and evaluations for the rest home and hospital. The total number of wounds are; one chronic leg ulcer, two reddened sacrum, two pressure area sacrum, pressure area shoulder, two skin tears, two oedematous leg ulcers, one fragile nail bed. Photographs are taken of chronic wounds to monitor healing progress. . There is access to wound care nurses and specialists as required. Wound care education has been provided. There is an improvement required around documentation of chronic wounds in the long term care plan.

Behavioural incidents are reported on incident forms and behavioural monitoring is initiated. There is an improvement required around the management of residents with challenging behaviours in the rest home.

Nutritional and fluid assessments are completed on admission and reviewed six monthly or earlier if required due to dietary changes or weight loss. Residents are weighed monthly. However there is an improvement required around weight loss management.

Pain assessments are completed for all residents on pain relief for new or chronic pain. The pain assessments are reviewed at least six monthly or earlier if required. Pain management is reviewed at the three monthly resident reviews with the MDT team. This is an improvement implemented following a finding at their previous audit.

**Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Moderate

Wound progress notes and chronic wound support plans are in place for chronic wounds. Behavioural incidents are reported on incident forms and behavioural monitoring is initiated. Nutritional and fluid assessments are completed on admission and reviewed six monthly or earlier if required due to dietary changes or weight loss. Residents are weighed monthly.

**Finding Statement**

(i) Care plan reviewed of a hospital resident does not document that the resident has a chronic wound that is currently being treated. (ii) Escalating behaviour assessments have not been completed for two rest home residents with new/escalating behaviours. (iii) There are no short term care plans describing interventions and strategies for the management of specific behaviours. (iv) Two residents with weight loss (one hospital and one dementia care) do not have a short term support plan in place for the management of weight loss. (v) There is no weight loss monitoring in place for the resident in the dementia care unit.

**Corrective Action Required:**

i) Ensure chronic wounds are linked to the long term support plan. ii) Escalating behavioural assessments and short term support plans are to be completed for new/escalating behaviours iii) Ensure short term support plans and monitoring is in place for resident with weight loss.

**Timeframe:**

1 month

**STANDARD 1.3.7 Planned Activities**

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Recreation staff have attended a variety of education through PSC peer support annually and through the recreation interest group that meets monthly in the Wairarapa. Staff have also attended "Spark of life" education seminars and Eden Principles.

The service has a van which allows the residents to remain integrated in the community for support groups. The recreational team leader and recreational officer both hold current first aid certificates.

Residents interviewed described going out to the RSA, Gladstone pub for lunch, and going on a day trip to Wellington.

Church services are held by various denominations including, Anglican, Seventh Day Adventists, Baptist, Reformed Church, Catholic and Presbyterian.

The facility has a close connection with the local Lansdowne Kinder garden who visited recently with some lambs.

There is a volunteer concert pianist who visits to entertain the residents.

An internet account has been set up for residents to use and residents interviewed have enjoyed being able to "Skype" with family members who do not live locally and use You Tube as a resource for tutorials on items/hobbies/crafts of interest.

All new residents have a recreation plan completed at admission as part of their care plan. Previous and current activities, family/whanau involvement,

community involvement is recorded. Spiritual and cultural preferences are also identified. The activities assessment and care plan is reviewed six monthly as part of the care plan review and any changes made. Evaluations are carried out and progress notes are completed. This is an improvement on previous audit.

The recreation team leader at Kandahar Home develops a monthly planner ensuring residents preferences are considered. The service has adopted the Eden principles and the recreation team leader interviewed was able to describe how the Eden principles are implemented. There are two volunteers who have completed an orientation who assist with the delivery of the activities programme. Activities are provided in both facilities seven days per week.

There is a men’s club and residents are completing a project of sanding down some items furniture to then varnish or paint.

The recreational officer assists with the programme in Kandahar Home two mornings a week and that is often when one on one time with residents is scheduled into the programme.

In Kandahar Court, the recreational officer who is not a qualified diversional therapist, works 29-32 hours per week. This also includes two mornings working at Kandahar Home. Activities are planned that are appropriate to the capabilities of residents. Residents are able to participate in an exercise programme as part of the facility's falls prevention initiative. There is also reminiscing, crafts, music and a variety of activities to maintain strength and interests. Participation in activities is voluntary.

The recreational officer at Kandahar Court described how a wife whose husband is a resident at Kandahar Court is encouraged to spend some time with her husband outside of the facility in an environment that is familiar to them both. When taking residents out to the Cosmopolitan club the recreational officer informs the resident's wife and they meet up and have a cuppa together at the club as they used to do prior to his admission to Kandahar Court.

There is a volunteer who comes in to play the piano and guitar to residents in Kandahar Court.

D16.5d. Residents interviewed at Kandahar Home are satisfied with the programme. Residents stated they are able to provide feedback and suggestions for activities at the resident meetings which are held quarterly.

**Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There are six monthly written reviews that include the resident’s general recordings and weight, review of risk assessment tools, any issues to be discussed with the GP. Three monthly MDT reviews occur. Long term support plans are updated to reflect the changes in clinical and medical care.

The resident/family are notified of the six monthly review and invited to attend. The GP examines the residents three monthly and reviews the medication chart. Monitoring charts such as food and fluid intake charts, blood sugar level monitoring, behaviour monitoring, and pain management monitoring charts are evidenced in use.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated

ARC: D16.3c: All initial care plans were evaluated by the RN within three weeks of admission

**Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Moderate

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy delivers all pharmaceuticals and collects the returns from both facilities. The facilities use a blister packed medication system. Medications are checked and signed by an RN on delivery. Any discrepancies are fed back to the pharmacy. The RN's receive annual education and undergo an annual medication competency. RN's have completed syringe driver training and refreshers through the local Hospice. Healthcare assistants (HCA) in the dementia unit and rest home administer medications. HCA competency includes a self-learning package, supervised medications rounds and practical audit. All medication competent persons attend annual education. All medications are stored safely in locked medication rooms. There are no standing orders in the rest home or dementia care unit. The rest home access the Hospital controlled drugs safes (one for liquids and injections and the other for blister pack CD's) and medication fridge. There are weekly controlled drugs checks and a six monthly pharmacy audit of controlled drugs in the Kandahar Home and Kandahar Court dementia unit. Currently the rest home do not have any residents on controlled drugs. Medication fridge temperature recordings in the hospital were observed to be inconsistent however this issue was identified prior to audit and corrective action implemented has addressed the issue. The medication fridge in the dementia unit is locked and there are weekly temperature recordings. Eye drops in use are dated on opening. This is an improvement implemented from the previous audit. There are no self-medicating residents. The medication trolley is locked when unattended which is also an improvement from the previous audit. A medication round in Kandahar Home was observed and staff complied with policy and procedure for the administration of medications. All medication signing sheets are correct and prn medications have the time medication is given. Controlled drugs are signed by two staff on the medication administration form. All medication charts have photo identification. PRN medications are prescribed with the indication for use. There is cautionary advice regarding resident medications, duplicate labels and antibiotic labels used. Allergies have been documented on eight of eight dementia unit medication charts and eight of eight medication charts in the rest home. Three of six medication charts in the hospital did not have allergies or nil known recorded on the medication charts.

Telephone orders can be taken by the RN and written on to the verbal order section on the medication chart. The GP signs these at the next weekly visit. Telephone orders are written on different forms (medication drug chart in the hospital and medication alert form in the dementia care unit). There is no continuity of medication practice for telephone orders therefore an improvement is required.

D16.5.e.i.2; 20 out of 22 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. Medication charts sampled in the rest home (eight) and hospital (six) had been reviewed by the GP at least three monthly. There are two of eight medication charts in the dementia care unit that have not been reviewed by a GP in the last three months.

**Criterion 1.3.12.1 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.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Moderate

Known Allergies or No Known Allergies is documented on dementia unit and rest home medication charts reviewed. Six of eight medication charts reviewed in the dementia unit have been reviewed by the GP three monthly.

**Finding Statement**

(i) Three of six medication charts reviewed in the hospital did not have allergies or no known allergies recorded on the medication charts. (ii) There are two medication charts in the dementia unit that have not been reviewed by a GP in the last three months, (iii) One telephone order in the dementia unit did not document the dose or frequency of the medication to be taken. Telephone orders are written on differing forms (medication drug chart in the hospital and medication alert form in the dementia care unit). There is no continuity of medication practice for telephone orders.

**Corrective Action Required:**

i) Ensure allergies/nil known allergies is documented on each resident medication chart. (ii) Ensure medication charts are reviewed at least three monthly by the GP, iii) Ensure the receiving and documenting of telephone orders follows medication policy.

**Timeframe:**

immediately - 1 month

**Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management**

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is a large workable kitchen at Kandahar home where the meals are provided for the rest home and hospital areas. Kandahar Court dementia care unit has a smaller kitchen with keypad access only. All meals, home baking and snacks are prepared on site at both kitchens. The qualified chef, cooks and kitchen hands have attended on-going education in food safety and hygiene. The PSC national menu for winter and summer is followed. The chef and cook have access to the company IT system (ordering, menus and recipes) and there are regular teleconferences with the company dietitian. Resident dietary profiles are forwarded to kitchen staff and resident likes and dislikes are known. The kitchens are notified if there are any changes. Special and modified diets such as vegetarian, gluten free, pureed are accommodated. Food is transported in Bain Marie to the dining areas in the Kandahar Home and hospital. Meals at Kandahar Court dementia care is served from the Bain Marie within the kitchen. Extra nutritious snacks are prepared daily in the afternoon, and are stored in fridges in all areas so that residents have access to these when required. E3.3f, There are adequate snacks available for the dementia unit. Advised by PSC clinical director that there is a company project underway with the dietitian for a "finger food menu" .All staff are observed wearing protective clothing. Fridge, freezer and chiller temperatures are recorded daily. Hot food temperatures are monitored daily. Recordings sighted at both facilities. The contracted chemical supplier provides the chemicals used, safety data sheets and also provide education as required. Quality control checks are carried out monthly. Feedback on the service is received from resident and staff meetings. The dietitian is readily accessible. The chef/cooks are informed if there are any resident weight or dietary concerns.

Seven of eight residents interviewed reported satisfaction with the meal service. One resident stated that they often don’t like what is on the menu. On further discussion the resident confirmed that she is provided with an alternative menu option of her choosing.

D19.2 staff have been trained in safe food handling.

**Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

**STANDARD 1.4.2 Facility Specifications**

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Kandahar rest home and hospital facility and Kandahar Court have a current building warrant of fitness that expires 01-Jul-2014.

ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, standing and full hoists, heel protectors, transfer belts, slippery sams and sensor mats.

Kandahar Court (dementia care) has relocated its main entrance to the front of the building near the visitor car park. The entrance is secure with keypad access for authorized personnel only. A pathway down the side of the building has been widened as a result of a family suggestion. Landscaping and gardening projects continue.

E3.4.c; There is a safe and secure outside area that is easy to access.

E3.4d, The lounge area in each of the two areas in Kandahar Court is designed so that space and seating arrangements provide for individual and group activities.

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

**Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS**

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is a restraint minimisation and safe practice policy that is applicable to the service. This includes a restraint protocol for the steps from assessment, approval and into the support plan. The aim of the policy and protocol is to minimise the use of restraint and any associated risks.

The service currently has a restraint free environment. There are currently five residents in Kandahar Home using enablers. The enablers in use in include one bed rails, two lap belts and two bed wedges. In Kandahar Court there are three residents requiring the use of an enabler which has been requested by their EPOA. They include two bed wedges and one bed rail.

Four enabler files reviewed (two from each facility) have appropriate consents indicating the enabler use is voluntary and assessments and three monthly reviews have been conducted. Two residents from Kandahar Home interviewed who use enablers confirmed their use was voluntary and at their request.

Care plans document the frequency of monitoring of enablers when in use. Progress notes document the monitoring of enablers when in use.

There is a restraint approval group at an organisation level that reviews restraint across all services. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0

**Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS**

**STANDARD 3.5 Surveillance**

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and Med lab that advise and provide feedback /information to the service.

The service utilises the QPS benchmarking programme which analyses service data on a quarterly basis. The quality coordinator also conducts benchmarking against their own infection rates from previous years by identifying K.P.I's. Systems in place are appropriate to the size and complexity of the facility.

Infection control data is collated monthly and reported to the monthly quality meeting. The meetings include the monthly infection control report and QPS quarterly results as available.

All infections are documented on the infection monthly on line register. The surveillance of infection data assists in evaluating compliance with infection control practices.

Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. One file of a resident with a current chest infection was reviewed. The care plan contained interventions to be implemented by staff.

Infection control reports reviewed and discussion with the infection control nurse confirmed that the facility has had no outbreaks of infections in 2013.

**Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**