

Presbyterian Support Central - Kandahar

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Presbyterian Support Central
Premises audited:	Kandahar Court Kandahar Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 24 November 2014 End date: 25 November 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	62

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

PSC Kandahar is part of the Presbyterian Support Central organisation and includes two facilities. One facility provides rest home and hospital level care and the other provides a secure environment for dementia care. The total number of beds available is 88. On the day of audit there were 24 rest home, 13 hospital and 24 dementia care beds occupied. There is a supportive and experienced non-clinical manager with an experienced clinical care manager at each site. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. There are adequate staff numbers on duty.

This audit identified improvements required around aspects of restraint and medication policies and practice, neurological observations and assessments.

The service has been awarded two areas of continuous improvement at criterion level. One for provision of services for Maori and the other for education and provision of literacy and communication education for staff.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in the foyer of the facility. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Informed consent and advanced directives are recorded for all residents. Staff training reinforces a sound understanding of informed consent and residents' rights and their ability to make choices. Support planning accommodates individual choices of residents', cultural and spiritual preferences. Residents and family interviewed spoke very positively about care provided at Kandahar Home and Kandahar Court. Complaints processes are implemented and complaints and concerns are managed within the required timeframes.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The service is managed by a non-clinical manager with management experience who has been in the role two years. He is supported by experienced clinical care managers and a registered nurse/quality co-ordinator. Clinical nurse specialist advice is available at head office. The service has implemented the Eden training and philosophy. Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and an external benchmarking

programme that has been implemented at Kandahar. 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. The service holds secondary level of workplace safer management practices certification.

There are improvements required around aspects of restraint and medication policies and neurological observations. Quality committee meetings include health and safety, infection control, review of incidents and accidents and discussion of quality and risk. There are also monthly qualified nurses 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 and staff state that there is sufficient staff on duty at all times.

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. The service has been awarded a continuous improvement rating around education and the provision of literacy and communication skills for staff with English as a second language.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service has a comprehensive admission policy. Comprehensive pre-admission information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. Registered nurses are responsible for each stage of service provision. Service delivery plans demonstrate service integration. Care plans are reviewed three monthly. Resident files include notes by the GP and allied health professionals.

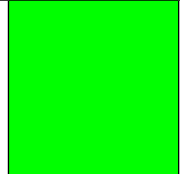
Improvements are required in relation to completion of assessments. During the tour of facility it was noted that all staff treated residents with respect and dignity and residents and families were able to confirm this observation. There is a recreation team who are responsible for activities, identifying different needs that are appropriate to their age culture and differing health status.

The recreation plan is developed on admission to the service identifying special needs, their likes, dislikes and past hobbies are discussed with the resident and family/whanau where appropriate and noted on their care plans.

There is a medication management system in place. Improvements are required around ensuring that practice meets medication administration requirements.

The company dietitian reviews the menu. Residents likes/dislikes and dietary preferences are known and alternative foods offered. There are nutritious snacks available in the dementia care facility 24 hrs per day. Residents are complimentary about the food services.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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PSC Kandahar has waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. The building holds a current

warrant of fitness and holds a current approved evacuation scheme. All electrical equipment is checked annually and clinical equipment calibrated. In the facility residents are able to bring their own possessions to promote a familiar environment. Consideration is given to residents needs when purchasing new furniture/equipment. The physical environment is appropriate and safe. There is adequate space and external areas are well kept. Laundry is completed on site and cleaning and laundry are monitored frequently. There is a staff member on duty at all times with a current first aid certificate and there are enough civil defence supplies, water and food to allow the service to be self-sufficient for at least three days in the event of a civil emergency.

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The organisational policies relating to restraint minimisation and safe practice require review to ensure that they align with current standards. Restraints in use are currently classified as enablers. Staff receive training in relation to restraint minimisation. The service maintains a restraint/enabler register in each level of service.

Improvements are required around documenting of associated risks of restraint for individual residents and recording of monitoring.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control policies and procedures are documented. Quality meetings are conducted monthly with infection control reports presented at each meeting and discussion occurring. Regular infection control audits and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings. Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control coordinator takes overall responsibility for ensuring that the surveillance programme is well implemented with review of trends and implementation of any recommendations. The service uses an external benchmarking programme for infection control. Surveillance information reviewed evidenced that trends are identified with corrective actions and outcomes communicated to staff. There is an online infection register in which all infections are documented monthly.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	6	1	0	0
Criteria	2	92	0	5	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The service has available information on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). The Code was evident around the service.</p> <p>There is a resident rights policy in place. Code of Rights training is included in orientation and included into the company study days.</p> <p>Discussion with four health care assistants (two rest home/hospital and two dementia care) and two ENs confirms they are all were aware of the code of rights and could describe the key principles.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Residents and their families are provided with all relevant information on admission. Discussions are held regarding informed consent, choice and options regarding clinical and non-clinical services. Informed consent obtained includes the following: collection and storage of information, delivering of care including minor procedures as wound care, X-rays and podiatrist, photograph for display and identification purposes, transport and outings, family involvement in assessment, care</p>

		<p>planning and evaluation of care and students delivering care. The consent forms also state the resident may withhold or decline to consent for any specific procedure. The two care managers, two registered nurses and four health care assistants interviewed were knowledgeable in the informed consent process. All resident files have a resuscitation form. The GP signs to deem the resident competent or not competent. Where the resident is deemed incompetent the GP discusses medical indications for or not for resuscitation with the EPOA or family. The GP and RN sign the resuscitation form. Nine resident files sampled (three rest home, three hospital and three dementia) had appropriately signed resuscitation forms.</p> <p>D13.1 there were nine admission agreements sighted and nine had been signed prior or on the day of admission.</p> <p>D3.1.d Discussion with six family identified that the service actively involves them in decisions that affect their relative's lives.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Client right to access advocacy and services is identified for residents and brochures are readily available. The information identifies who the resident can contact to access advocacy services. Information provided to residents and family/whanau at the time of entry to the service includes advocacy information. Staff (interviewed) are aware of the resident's right for advocacy and how to access and provide advocate information to residents if needed. The welcome booklet includes a section around 'client advocates'.</p> <p>D4.1d; Discussion with six family members identified that the service provides opportunities for the family/EPOA to be involved in decisions.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Family members and residents confirm that visiting can occur at any reasonable time. This is stated in the resident information pack.</p> <p>D3.1h Discussion with six residents shows that they are encouraged to be involved with the service and in their care.</p> <p>Residents can access community services as they require. Discussions with staff, residents and relatives identified that the service encourages</p>

		<p>residents to belong to community groups. There is interaction with the local marae. There are community volunteers, and community groups visit and entertain.</p> <p>D3.1.e Discussion with RNs, HCAs, the recreation officer and the care managers indicates that residents are supported and encouraged to remain involved in the community and external groups visit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a clearly documented process for making complaints and this is communicated to residents/family/whānau. Residents and family members confirmed that management are very approachable should they have any concerns. Complaints information is included in the resident and relative information pack. The complaints form is readily available and attached to Enliven complaints brochure. The brochures are displayed in the entrance of both facilities.</p> <p>There is a complaints folder and register that includes verbal and written complaints 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 with evidence of follow up and resolution. There has been two complaints in 2014. The complaints have been appropriately investigated and resolved to the satisfaction of the complainant. Advocacy was offered and the privacy officer (facility manager) has completed a six week follow up. One complaint (2013) remains open with the Health & Disability Commissioner.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Resident's rights information is available. The code of rights and advocacy pamphlets are located in the foyer at the entrance of the rest home/hospital facility and the dementia care facility.</p> <p>D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, a code of rights pamphlet, advocacy and Health and Disability Commission information.</p> <p>The Code is available in formats appropriate to the communication preferences or needs of residents, such as audio tape. The interpreter</p>

		<p>service information is also available.</p> <p>Staff will read information to residents and explain it (e.g. informed consent and code of rights). Information is also given to next of kin or enduring power of attorney (EPOA) to read to or with the resident and discuss in private.</p> <p>On entry to the service the manager or care manager discusses the information pack with the resident and the family/whanau. This includes the code of rights, complaints and advocacy.</p> <p>Six residents (three hospital and three rest home) and six relatives (two hospital and four dementia) stated they were well informed about the code of rights and the service provides an open-door policy for concerns/complaints.</p> <p>Information on complaints and compliments includes information on advocacy.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records.</p> <p>There is a comprehensive resident records policy that includes; a) integrated resident records, b) information requirements, and c) integrity of computerised records.</p> <p>Discussions with residents and family members identified that personal belongings are not used as communal property.</p> <p>The staff are observed to be respectful of entering a resident's room and gained permission before doing so.</p> <p>D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.</p> <p>D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission</p>

		<p>agreement. Personal belongings are documented and included in resident files.</p> <p>D4.1a: The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. The support plan includes a 'spirituality, faith and culture' section. The service includes within its care planning assessment, directions for emotional wellbeing and this includes sexuality and intimacy.</p> <p>Discussions with residents and family members confirmed that residents are able to engage in activities and access community resources as they choose. Discussion with health care assistants could describe examples of giving residents choice including, what time they would like to get up, choices on food, and what they would like to wear.</p> <p>The service implements the Eden Philosophy and staff could describe a more resident-focused care instead of task orientated.</p> <p>There is an elder abuse and neglect policy and abuse or neglect reporting process. Elder abuse and neglect training is compulsory to attend at least every two years as part of the health care assistant (HCA) and registered nurse (RN) study days. Discussions with management (the quality coordinator, the care managers and the facility manager) and staff identified that there were no incidents of abuse or neglect and that there is a culture of reporting.</p> <p>Family members and residents interviewed are very positive about the quality of care and support provided to residents.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>A3.2: There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). The Presbyterian Support wide Maori Health plan has been reviewed and updated through the Maori Health plan Wellington Group. There is a site specific Maori health plan.</p> <p>The service identifies the need for staff to be trained in delivering appropriately cultural services.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. There is a spirituality, religion, faith and culture section in the care plan.</p> <p>D3.1g: The service provides a culturally appropriate service by identifying individual needs.</p> <p>D4.1c: Care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</p> <p>The service provide a chaplaincy service and on-site church services.</p> <p>Discussions with residents and family members confirmed they were satisfied that staff considered their individual values and belief. This was also reflected in support plans.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There is a code of ethics policy. Job descriptions include responsibilities of the position and ethics, advocacy & legal issues. Registered Nurse and Enrolled nurse job descriptions include upholding legal and ethical standards and accountability and responsibility. The orientation booklet provided to staff on induction includes a section on professionalism and standards of conduct, harassment prevention policy and gifts.</p> <p>Understanding the code of conduct and information technology (IT) usage policy is signed as part of orientation. Completed orientation packages were sighted in all ten staff files sampled.</p> <p>All staff interviewed have a good understanding of professional boundaries.</p> <p>Residents and family members report that staff are always professional.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>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.</p>

		<p>Policies and procedures cross-reference other policies and appropriate standards (link 1.2.3.3).</p> <p>RNs are encouraged and supported to continue education. Health care assistants are supported to complete Career Force or unit standards and the Eden Way.</p> <p>A2.2 Services are provided at Kandahar that adhere to the health & disability services standards. There is an implemented quality improvement programme that includes performance monitoring.</p> <p>D1.3 All approved service standards are adhered to.</p> <p>D17.7c. There are implemented competencies for HCAs, enrolled nurse and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.</p> <p>Resident meetings are held regularly. Family meetings are held six monthly with guest speakers invited to attend. The chaplain attended the last family meeting in March 2014 and spoke about the grieving process. Relatives were invited to attend an evening with staff to hear a specialist speak on dementia care.</p> <p>Staff attend compulsory education and study days. Staff have access to the Enliven library which includes gerontology journals and updated best practice guidelines. Staff are required to read information/reviewed policies and procedures in the reading folder and sign to acknowledge they had read them. Shift handovers ensures there is continuity of service delivery. Four health care assistants interviewed are knowledgeable in the use of care plans and short term care plans which guide them in the safe and timely delivery of services for the residents.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Discussions with residents and family members all stated they were welcomed on entry and were given time and explanation about the service and procedures. Resident meetings occur three monthly and the facility manager and has an open-door policy. Relatives were invited to an education evening in March 2014 with the dementia care specialist.</p> <p>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</p>

		<p>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.</p> <p>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.</p> <p>D16.4b. Relatives stated that they are always informed when their family members health status changes.</p> <p>D 13.3 Nine resident admission agreements sighted are signed. The admission agreement contains a schedule of fees and charges where applicable.</p> <p>Residents and relatives interviewed confirmed the admission process and agreement were discussed with them and they were provided with adequate information on entry. The admission agreement has recently been reviewed at an organisational level to make it more user friendly for residents and families.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents. There has been a relatives and friends information booklet developed.</p> <p>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.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Kandahar Home (18 rest home beds, 25 hospital beds and 20 dual purpose beds) and Kandahar Court (25 dementia care beds) are part of the Presbyterian Support Central organisation. The service provides rest home, hospital and dementia care levels of care for up to 88 residents. On the day of the audit there were 62 residents. There were 24 rest home residents, 13 hospital level residents, and 24 dementia care residents (includes one respite).</p> <p>The facility manager (non-clinical) has been in the role for two years and has 20 years aged care management experience within the area of homecare in the United Kingdom and New Zealand. The facility manager is responsible for the daily operations of both Kandahar</p>

	<p>facilities, the support staff and recruitment. He is supported by a quality co-ordinator/educator who is a registered nurse (RN) and has been in the role for three years with experience in aged care. There is a RN care manager at each site both with considerable experience in aged care. The facility manager is supported by a regional manager (non-clinical) who visits the site weekly. Peer support is provided through quarterly management meetings held at head office. The management team (interviewed) feel well supported by the company. Central office have recently appointed three clinical consultants who have been allocated to mentor and support care managers.</p> <p>Kandahar has a documented mission statement, vision, values and goals included in the Enliven Kandahar 2014-2015 business plan. Residents and staff are involved in the business planning process. There is a company operational plan and site risk management plan that evidences a review for 2013. Kandahar management and staff are committed to implementing the Eden philosophy within the homes. Nine staff have completed their Eden associate training and attend monthly Eden meetings. All staff attended sessions provided by an external dementia specialist with a focus on person centred care. The recreational team are involved with the resident/family in developing the resident's individual "Eden trees" and staff are encouraged to record Eden moments in the resident progress notes. The environment aligns with the Eden values and philosophy. There are four "home "cats and the manager's dog is on-site during the week. One of the goals is to increase the number of volunteers and increase staff and resident involvement in the community. Recently staff and residents took part in the community dementia awareness "memory walk". The service enjoy a good relationship with local school children who visit both facilities weekly to read and sing to the residents.</p> <p>Enliven provides a two day education seminar annually for all care managers that ensures all care managers receive at least eight hours annual professional development activities related to overseeing clinical care.</p> <p>ARC D17.4b The manager has maintained at least eight hours annually of professional development activities related to managing a rest home/hospital/dementia care unit.</p>
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<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the facility manager an individual with relevant experience is delegated with the responsibility of fulfilling the manager role. The delegated person is the rest home/hospital care manager with support from the regional manager.</p> <p>D19.1a; A review of the documentation, policies and procedures and discussion with staff identified that the service has operational management strategies and a quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The service has well established quality and risk management systems. The organisation has committed resources and has available a quality coordinator/RN on-site. The service has continued to implement their quality and risk management systems. PSC has an overall Quality Monitoring Programme (QMP) that is part of the quality programme with external quarterly benchmarking. Quality meetings (includes health and safety and infection control) involves key staff from all areas of service. Quality reports are provided to the committee. Staff meetings are held monthly and meeting minutes evidence discussion around quality, health and safety and infection control, audit outcomes and corrective actions. 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.</p> <p>The 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. There is an internal audit schedule in place and the service completes the mandatory audits and chooses an additional audit monthly. Quality improvement forms are raised with corrective actions for audits where there are areas of</p>

		<p>concern. A copy of the audit results are attached to meeting minutes. The internal audit programme is currently being reviewed to involve to include other staff in the auditing process. Two weekly team leader meetings have been initiated to discuss audits and outcomes. When an audit shortfall is identified the area is re audited until a satisfactory result is obtained. The quality co-ordinator (interviewed) is responsible for ensuring corrective actions have been implemented and signing off audit reports. Annual resident satisfaction surveys are completed as per company schedule. Results are communicated to the relevant committees and staff.</p> <p>The service documents risk or areas of concern and remedial action is identified as a result. Monthly accident/incident/ reports are completed by the care manager/facility manager. Monthly data is collected across the facility including staff incidents and accidents. These are compared with the last month. The monthly reports provided to staff via meetings and staff notice boards include the external benchmarking indicator results that includes analysis of manual handling injuries, skin tears, pressure areas, resident falls, resident accidents, medication errors, and staff accidents. There is an online database for recording accidents and incidents with medication errors reported separately. Incidents and accidents are also reported to PSC clinical director monthly.</p> <p>D19.2g: Fall prevention strategies such as sensor mats and individual review of residents who fall is in place. A falls project has been commenced to reduce the number of falls. The hospital care manager has attend the regional falls prevention course and focused on raising staff awareness and fall prevention strategies. Each unit has a plan of the building on a whiteboard in the nurse's station where falls, location and time are plotted on the plan for visual impact. Interventions include selecting a "faller "as a resident of the moment with a focus on the residents needs and identification/contributing factors for falls. The time for Tai Chi sessions have been changed to better suit residents which has resulted in greater attendance, use of sensor mats and hip protectors for all fallers. A falls information pamphlet is provided to residents and families. A physiotherapist has been contracted in August for four hours a fortnight for the assessment of residents, equipment and staff safe manual handling training. The physiotherapist liaises with the recreational team and the health and safety representative.</p>
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<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Low</p>	<p>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.</p> <p>Fifteen accident/incident forms for Kandahar court (dementia care unit) in October 2014 were sampled. Twelve accident/incident forms for Kandahar home (rest home/hospital) in October 2014 were sampled. All accident/incident forms have been fully completed and residents reviewed by a registered nurse. All have on-going review and where</p>

		<p>appropriate actions to prevent recurrence completed by either the care manager or the quality co-ordinator. There is evidence of relative notification on all 27 accident/incident forms.</p> <p>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 that is then displayed for staff information. The monthly reports are discussed at all clinical meeting and staff meetings and include the QPS benchmarking indicator results and analysis of manual handling injuries, skin tears, pressure areas, resident falls, resident accidents, medication errors, and staff accidents.</p> <p>D19.3b; There is a requirement to complete neurological observations as per head injury protocol.</p> <p>D19.3c Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>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, enrolled nurse, pharmacists, podiatrist, physiotherapist and GPs is kept.</p> <p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Ten staff files were reviewed. Each folder had a recruitment file checklist and documentation arranged under personal info, correspondence, agreement, education and appraisals. Annual appraisals have been completed for eight of ten staff files sampled. Two staff have not been employed with the service long enough for an appraisal.</p> <p>A generic orientation programme is in place that provides new staff with relevant organisational information for safe work practice. This was described by staff and records are sighted. Staff are allocated three days to complete the generic orientation booklet. The new staff member is supported during their orientation to their work area. There is an implemented specific RN orientation book and RN competencies are</p>

		<p>completed. Six RNs have achieved competent status in professional development recognition programme with the district health board (DHB).</p> <p>Healthcare assistants (HCAs) attend study days as scheduled to meet mandatory education requirements. The quality co-ordinator co-ordinates the education and maintains in-service records on the intranet. The service has four career force assessors to work with students and complete assessments. The educator also supports staff through their orientations and sign off when completed. HCAs and support staff are encouraged and supported to undertake external education. All education sessions are evaluated. Career force training is supported. The organisations policy is that after three months of employment all caregivers and support staff must be enrolled in Career Force. Education and provision of literacy and communication education for staff is an area of excellence.</p> <p>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 HCAs. All individual records and attendance numbers are maintained on-line. Monthly reporting of training completed and staff attendance is reported to the regional manager and clinical director monthly.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>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.</p> <p>The care managers (rest home/hospital and dementia care unit) work 40 hours per week plus on call. Registered nurses cover each 24 hour period in the hospital area. Enrolled nurses are also employed seven days a week on morning and afternoon shifts in the rest home/hospital wings.</p> <p>The HCA numbers per area are adequate. Staff interviewed including four HCAs, two enrolled nurses, two care managers and two RN's report adequate staff cover. Agency staff are used to provide cover for sickness if necessary. Six residents and six family interviewed report</p>

		adequate staffing levels.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type.</p> <p>Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure nurse's station within the rest home/hospital areas and in the dementia care unit. Support plans and notes are legible and where necessary signed and dated with designation of the person making the entry. Policies contain service name. Resident records reviewed contain the name of resident and the person completing the form/entry.</p> <p>D7.1 Entries are legible, dates and signed by the relevant health care assistant, enrolled nurse or registered nurse including designation. Individual resident files kept demonstrate service integration with an allied health section that contains GP notes and the allied health professionals and specialists involved in the care of the resident.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The needs assessment coordination service (NASC) ensures all residents are assessed prior to entry for rest home, hospital or dementia level of care. A placement authority form is sent to the receiving facility. The care managers (one rest home/hospital and one dementia unit) are responsible for the screening of residents to ensure entry has been approved. The potential resident and family receive a tour of the facility and are introduced to staff. An information booklet is given out to all residents/family/whanau on enquiry or admission. The information pack includes all relevant aspects of service and associated information such as the Health and Disability Code of Rights and how to access advocacy. There is an admission procedure in place and admission documentation which includes resident and next of kin details. The care managers (interviewed) were able to describe the entry and admission process. Discussion with the referrer/resident/family takes place and a suitable</p>

		<p>time is arranged for admission. The RN on duty completes all the admission documentation and relevant notifications of entry to the service. Signed admission agreements are sighted. Six residents and six relatives interviewed state they received all relevant information prior or on admission. The GP is notified of the new admission.</p> <p>E4.1.b There is written information on the service philosophy and practices particular to the 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 minimising restraint, behaviour management and complaint policy.</p> <p>D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract. Nine admission agreements sighted had been signed.</p> <p>D14.1 Exclusions from the service are included in the admission agreement.</p> <p>D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p> <p>E3.1 three dementia resident files reviewed included a needs assessment as requiring specialist dementia care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The service has policies for transfer or exit of the service which describes guidelines for death, discharge, transfer, documentation and follow up. There is a discharge or transfer of resident to another facility policy. All relevant information is documented and communicated to the receiving health provider or service. A DHB transfer form accompanies residents to receiving facilities with a transfer letter, with accompanying photocopied relevant documentation including medication charts. The registered nurses are available for any follow up or queries.</p> <p>Six residents interviewed and six family members interviewed are satisfied that they are kept well informed in regard to referrals and/or transfer to hospital where this has occurred. Staff could describe the referral and or transfer processes and demonstrated an understanding of resident right to be informed.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policies and procedures comply with medication legislation and the Medicines Care Guides for Residential Aged Care. PSC Kandahar has appropriate safe medication storage facilities, to ensure that medications will be appropriately stored and safely managed. The service has an agreement with a local pharmacy for the supply of medications.</p> <p>The service use four weekly blister packs. Medications are checked on arrival by a registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy. Medication charts have a photo identification of the resident and allergies or nil known allergies are documented. There is a medication fridge in the hospital treatment room which is monitored and temperature recordings were sighted. A medication fridge is available in the dementia unit nurses' station.</p> <p>Two medication rounds were observed – one in the hospital area and one in dementia unit. The registered nurse and enrolled nurse administering the medications observed the correct procedures and checks. Policy states that staff with medication responsibilities must have their competency reviewed every three years. This does not align with best practice (link #1.2.3). Registered nurses and enrolled nurses administer medications to rest home and hospital level residents. The care manager, enrolled nurse or senior health care assistants administer medications to dementia level residents.</p> <p>Medications are kept in locked trolleys and then in locked medication rooms when not in use. There is a main locked treatment room in the hospital area where the hospital trolley and controlled drugs are also stored. The rest home wing has a locked medication room where the medication trolley is stored. The dementia unit has a locked medication room where medication packs and supplies are kept. The dementia unit trolley is kept in the locked nurse's station when not in use.</p> <p>Controlled drugs are stored appropriately. Only the registered nurses have access to controlled drugs and two people (one being an RN) sign out controlled drugs in the rest home/hospital facility. Both controlled drug registers are well kept and align with legislative requirements. Weekly controlled drug checks are completed by registered nurses.</p>

		<p>There are currently five hospital residents assessed as self-administering medications. The residents have been assessed as being safe to self-administer medication and this is noted on the care plan. However, the practice of self-administration does not align with facility policy and procedure.</p> <p>Eighteen medication files were reviewed (six rest home, six hospital and six dementia unit residents). Medication charts are generated from the pharmacy based on the resident's prescriptions and are then signed by the nurse practitioner or GP. Regular medications are pre-packed in blister packs. Non-packed medications including PRN and short course are all appropriately charted. Medication signing sheets for regular items are printed from the pharmacist. It is noted that for resident's required regular insulin, the administration record is included within the general pre-packed signing of medications. All medication charts reviewed identified that the GP or nurse practitioner had seen the resident and reviewed the medication chart at least three monthly and all medications had been signed for.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The Kandahar Court and Home kitchens have been reviewed and will be centralised to the Home kitchen on 1 December 2014. Food services policies and procedures manual is in place. There is a qualified chef on duty each day supported by with two morning kitchen hands and an afternoon kitchen hand to serve tea. There is a five weekly summer and winter menu that is reviewed by the company dietitian. The company dietitian is readily available to the cook by email/phone for advice if required. The cooks receive peer support by teleconference bi-monthly and when all the PSC cooks meet annually. All residents have a dietary requirements/food and fluid chart completed on admission. The chef maintains a folder of residents likes/dislikes and alternative choices are offered. The cook is informed of dietary changes such as high calorie/high protein diets for weight loss. Dietary needs are met including normal, soft, pureed, vegetarian and finger foods. The main meal is midday lunch. The meals are delivered to the rest home and hospital in bain maries and served to the residents by kitchen staff. The Court have meals delivered in hotboxes in the van that has been modified for the purpose. Residents interviewed commented very positively about the meals provided. Residents have the opportunity to</p>

		<p>provide feedback and suggestions on food services at the resident meeting. Specialised plates, cups and cutlery are available to promote resident independence at meal times.</p> <p>The kitchen is well equipped with a good work flow. There is a walk-in chiller, freezers and fridges, combi-oven and gas hobs. Hot food temperatures are monitored on each meal. Fridge and freezer temperatures are recorded twice daily. All facility fridges are monitored. All foods are date labelled. The dry goods are sealed, labelled and off the floor. Goods are rotated weekly with the delivery of food orders. Chemicals are stored safely within the kitchen. Personal protective equipment is readily available and observed to be worn correctly on the day of audit. Cleaning schedules (sighted) are in place and maintained.</p> <p>E3.3f. There are nutritious snacks available 24 hours in the dementia care facility.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service has accepting/declining entry to service policies. Pre-approved residents seeking admission are not declined, providing there are vacant beds. The resident and or family/whanau are informed of the reason for declining entry if this should occur. Reasons for declining entry would be if there were no beds available or the service cannot provide the level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Low</p>	<p>Assessment information is gathered from a variety of sources, including the resident, their family and allied health professionals, and a variety of assessment tools. Six of nine resident files reviewed (two rest home, two hospital and two dementia) evidenced appropriate assessment tools are used as a basis for care planning. A range of assessment tools were available including (but not limited to); falls risk, pressure area risk, nutrition assessment, continence, pain and behaviours. An initial assessment was completed for seven of nine files reviewed. A comprehensive assessment is conducted during the first three weeks of admission for seven of nine resident files reviewed. Mobility and handling assessments are completed as well as a life review/social assessment. The long term care plans addressed all assessed needs.</p>

		<p>Advised by care managers (two) that the service has commenced the use of the InterRAI assessment tool, however, this was not evident in the nine files reviewed.</p> <p>Six residents and six families interviewed advised that they were involved in the development of the care plan and were aware that where appropriate, this information is shared with other health professionals involved with the residents care.</p> <p>E4, 2a Challenging behaviours assessments are completed. Behaviour nursing care plans are in place for three dementia level resident files reviewed.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>In nine of nine care plans reviewed (three rest home, three hospital and three dementia) the care plans are individualised and consumer focused. The care plans are current and there is evidence of changes to the care plan with a change in health status. Each aspect of the care plan links to assessments conducted and are individual and resident focused. The three aspects of the Eden approach are documented for each resident and includes interventions to relieve helplessness, loneliness and boredom. Three monthly resident reviews and changes to resident's health status are documented in the care plans of eight long term residents and one respite resident and signed by the registered nurse. There is evidence of the use of short term and long term care plans. The care plans are comprehensive and includes the outcomes from risk assessments. In care plans reviewed there is evidence of resident and family involvement. Resident and families advised that they were involved in the development of the care plan. Staff use the care plan to ensure continuity of care delivery is maintained confirmed by the two rest home/hospital health care assistants (HCA), two dementia unit HCA's, two enrolled nurses, two registered nurses and two care managers. This is supported by external agencies providing input such as diabetic, psychogeriatric or podiatry as well as a recreational and lifestyle plan providing an integrated approach. The health status report includes notes by GP and allied health professionals, significant events, communication with families and notes as required by RN. Wound care plans for reviewed for all residents with wounds (three rest home, three hospital and six dementia residents). All wound documentation was up</p>

		<p>to date and included wound assessments, treatment plans, wound photographs, and wound healing progress and evaluations.</p> <p>E4.3 Three of three dementia resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.</p> <p>D16.3k, Short term care plans are in use for changes in health status. Examples sighted are as follows: weight loss, wounds and skin tears, pain, behaviours, inflammation, falls, dry skin, medication changes, sore eyes, shingles and decreased appetite.</p> <p>D16.3f; Nine resident files reviewed identified that the resident/family are involved in the development/evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Discussion with residents, family, HCAs, and registered nurses confirm that residents assessed needs are being met. There is evidence of three monthly medical reviews. Relatives are notified of changes in a resident's condition as evidenced in nine of nine resident files sampled and on interviews with six family members. Staff document in residents' progress notes on each shift and document any changes in care/condition of residents. Staff were observed accessing the care plans on the days of audit.</p> <p>The care staff interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Staff state that when something that is needed is not available, management provide this promptly. Sighted on the day of the audit were thermometers, a sphygmomanometer, a stethoscope, chair scales and blood glucose testing equipment. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted. Wound care plans were comprehensive and evidenced assessments, photographs of progress, treatment plans and evaluations. Wounds included chronic leg ulcers, bruising, infections, and skin tears. One dementia resident has a healing sacral pressure area.</p> <p>Falls and incident forms were completed, with improvements required in</p>

		<p>relation to post fall management of suspected head injuries (link #1.2.4.2).</p> <p>Six residents and six family members interviewed are complimentary of care received at the facility and felt they were well care for.</p> <p>Residents identified with behavioural or challenging behaviour have a behavioural assessment completed and behaviour plan that identifies the behaviour, triggers and interventions including activities over a 24 hour period that can be best used to manage behaviours. Behaviour monitoring charts have been utilised for dementia residents to monitor behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>A recreation team leader works 30 hours per week in the rest home/hospital facility. There are recreational programmes running that are meaningful and reflect ordinary patterns of life. On the day of audit, residents were observed participating in a variety of activities. There is evidence of the wider community involvement with outings each week to local places of interest, visits to the local library, guest speakers, monthly church services, inter - rest home bowls competitions, and pre - school groups visiting. Entertainers come to the facility twice a month and volunteers provide regular support to the programme. Residents and families spoken to report satisfaction with the activities programme.</p> <p>A recreation coordinator also works across the rest home/hospital facility and the dementia unit and there are activities provided from Monday to Saturday. An HCA training as a diversional therapist also assists with the dementia programme. Resources are available at both sites for care staff to access when recreation staff are not at work. The recreation team are responsible for the resident's individual recreational and lifestyle plans which are developed within the first three weeks of admission. The resident/family/whanau, as appropriate, is involved in the development of the plan. The recreational plan and lifestyle plan identify the residents special needs, their likes dislike and past hobbies. The residents at PSC Kandahar have an activity plan that is consummate with their needs and functional capabilities. Frequent van outings are arranged.</p> <p>Activities are planned that are appropriate to the functional capabilities of</p>

		<p>residents. Residents are able to participate in indoor bowls, and an exercise programme. There is also a reminiscing, crafts, music and a variety of activities to maintain strength and interests. Six residents (three rest home and three hospital) and six family members (two hospital and four dementia) were satisfied with the programme and advised that participation is voluntary. Hospital and rest home residents were observed to be enjoying the activities programme at Kandahar home and hospital. Residents are able to provide feedback and suggestions for activities at the quarterly resident meetings and annual resident satisfaction survey. The activities provided are in keeping with the strengths, interests and needs identified in each resident/s activities plan and include group activities and one to one activities for residents who have needs which cannot be met in a group setting.</p> <p>In the dementia home there is a variety of activities including puzzles, book and newspaper reading, ball games, exercises and walks, houseie, church services, craft, entertainment, music, baking and one on one activities. Doll and pet therapy is also in use.</p> <p>D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at the same time as the care plan review.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Eight of nine resident files sampled (two rest home, three hospital and three dementia) evidenced care plans which have been reviewed within the last six months. One of three care plans was for a rest home respite resident and there was no evaluation due. Support plans are reviewed and evaluated by the registered nurse at least three to six monthly.</p> <p>Evaluations are conducted by the registered nurses with input from the GP, the HCAs, the resident, the family and the recreation coordinator. Changes in health status are documented in the progress notes and on the short term care plan if not considered a long term change of health. Ongoing problems are transferred to the long term care plan. Three monthly clinical and medication reviews are conducted by the medical practitioner and the nurse practitioner.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>There is a referral policy. Referral to other health and disability services is evident in a sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Referrals are initiated either by the service or the GP or nurse practitioner. The two care managers, one nurse practitioner and two registered nurses interviewed state that referrals are initiated to nurse specialist services. Referrals and options for care are discussed with the family. Referrals sighted on the resident files sampled are as follows: physiotherapy needs assessor, and physiotherapist.</p> <p>D 20.1: Discussions with registered nurses identified that the service has access to dietitian, physiotherapy, speech language therapist, wound care specialist, podiatrist and mental health nurses and practitioners, hospice nurses and specialists.</p> <p>D16.4c: The service provided an examples of where a resident's condition had changed and the resident was reassessed for a higher level of care such as respite care to dementia level of care, dementia care to hospital level care and rest home care to hospital level care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. The chemical supplies are placed into locked storage on delivery. The maintenance person monitors the chemical use and distributes to the kitchen, cleaning and laundry areas for use. The chemical supplier provides the chemicals and associated safety data sheets. Chemical safety training is scheduled for December 2014. Wheelie bins are used within the facility to collect general waste and collected regularly by the council. Approved containers are used for the safe disposal of sharps. Staff have attended waste management education. Personal protective equipment (gloves, aprons, goggles) are readily available to staff and observed to be worn correctly on the day of audit. A chemical spills kit is available.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The facility has two sites both with a current building warrant of fitness that expires 1 July 2015. The interiors of both facilities are well maintained and provide a home-like environment with spacious communal areas and several seating areas with garden outlooks. There is a maintenance request book that is checked and addressed daily by the maintenance person. There is a planned maintenance schedule that also includes monthly checklists such as fire safety, equipment checks and hot water temperature monitoring. Electrical equipment has been tested and tagged annually. Clinical equipment has been calibrated. There is safe access to external areas. There is adequate space to promote residents' mobility and freedom of movement. The site has its own vehicles which are regularly used for resident outings. Multiple equipment storage areas were observed and staff spoken to confirm there are adequate equipment storage areas.</p> <p>ARC D15.3. The four health care assistants interviewed stated that they have all the equipment referred to in care plans necessary to provide care, including electric beds, ultra-low beds, landing mats, sensor mats, shower trolleys, commodes, slide sheets, sling and standing hoists, wheel-on scales, wheelchairs, lazy boy chairs on wheels, mobility aids, continence supplies, dressing and medical supplies.</p> <p>E3.3e; There are quiet, low stimulus areas that provide privacy when required.</p> <p>E3.4d; the lounge areas in both unit are designed so that space and seating arrangements provide for individual and group activities.</p> <p>E3.3c; There is a safe and secure outside area.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate communal toilets that are easily accessible and signed and some rooms have ensuite toilets and /or showers. Resident interviews and caregiver interviews (from both areas) confirm there are adequate number of bathroom facilities. There are adequate disabled size bathrooms. Hot water is monitored monthly and kept under 45 degrees. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is adequate room in residents' bedrooms for personal belongings and room for both staff and residents in the provision of safe care when using mobility and transferring equipment. Residents interviewed and HCAs interviewed confirm there is adequate space in residents' bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is good access for residents to lounges, quiet areas, and dining areas that meet the needs of the residents. Staff assist residents to access communal living areas as required and observed on the day of the audit. All seven residents interviewed confirm there are number of internal and external areas they are able to access for relaxation and staff assist them to access the lounges and the dining rooms if they require this. There are two main lounge areas to allow for activities, resident relaxation and provide privacy for residents and visitors. Each wing has a smaller lounge. The facility design allows for freedom of movement for all residents including those with mobility aids.</p> <p>D15.3d: Seating and space is arranged to allow both individual and group activities to occur.</p> <p>E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The service has in place policies and procedures for effective management of laundry and cleaning practices. Laundry and cleaning processes are monitored for effectiveness. There is a designated area for the storage of cleaning and laundry chemicals. There is a laundry manual available that includes the use of personal protective equipment, handling of linen, waste disposal and with hazard controls. The laundry and cleaning room is a designated area and clearly labelled. Chemicals are stored in locked cupboards. All chemicals are labelled with manufacturer's labels. Safety data sheets are readily available. The laundry service is under review and will be centralised to the Kandahar home in December.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Appropriate training, information, and equipment for responding to emergencies is provided. Fire training is completed at orientation and fire evacuations are held six monthly. Fire drill was last completed on 8 and 9 September 2014. The fire service approved an evacuation plan on 1 July 1998.</p> <p>D19.6 there are emergency management plans in place to ensure health, civil defence and other emergencies are included. Kandahar is well prepared for civil emergencies and has civil defence supplies readily available including torches and radios. There is a tank reservoir of water on each site for use in an emergency. A barbeque and gas cooker is available for cooking. There is emergency food supplies sufficient for three days. There are other products for at least three days such as incontinence products and personal protective equipment. There is a store of supplies necessary to manage a pandemic. Two generators have been purchased for each site to use in an emergency and training provided in the use of the generators.</p> <p>There is an appropriate call bell system that is easily used by the resident or staff to summon assistance if required. Call bells are accessible and within easy reach, and are available in resident areas, e.g. bedrooms, communal toilets, ensuite toilet/showers, lounges and dining rooms. During the tour of the facility and during interviews, residents were observed to have easy access to the call bells. The call bell system including the door alarms are connected to pagers. The facilities are secured at night. Residents interviewed stated their bells are answered in a timely manner.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Kandahar Home and Kandahar Court are light with an ambient temperature that is maintained to ensure it is comfortable. Resident's rooms have access to natural light with external windows and there is adequate external light in communal areas. Smoking is only permitted in the designated area.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is a QPS benchmarking system in place. The scope of the infection control programme policy and infection control programme description is available. There is an established and implemented infection control programme that is linked into the risk management system. The committee and the governing body are responsible for the development of the infection control programme and its review dated August 2014. The infection control coordinator (IC) is a RN in the hospital/rest home facility and also oversee the dementia care facility. The infection control co-ordinator has a signed job description. The infection control co-ordinator provides a report to the quality committee and the qualified nurses meetings. Meeting minutes are available to all staff.</p> <p>There are guidelines and staff health policies for staff to follow ensuring prevention of the spread of infection. There are hand sanitizers available throughout the two facilities and notices advising people not to visit if they have been unwell. There have been no outbreaks in the last two years.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control criteria policy states the infection control co-ordinator and committee members work in liaison with the health and safety committee. Infection control meetings are combined with quality meetings. The quality committee is made up of a cross section of staff from all areas of the service including; management, clinical, support services and maintenance. The infection control co-ordinator has access to the IC nurse at the DHB, GP and nurse practitioner and laboratory services. The IC co-ordinator has access to infection control expertise at head office.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are</p>	<p>FA</p>	<p>The infection control policies and procedures are developed and reviewed by an external infection control specialist. The manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and</p>

<p>implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>education of staff.</p> <p>Other policies included (but not limited to) a) definition of infection for surveillance, b) IC programme description, c) standards for IC practice – cleaning, food service, linen service, waste management, d) policy and guidelines for antimicrobial usage, e) standard precautions, f) risk management of blood, g) hand hygiene, h) hand care procedures, i) UTI's, j) clinical indicators of infection, k) Hep A & B & C, l) Inoculation/contamination emergency response, m) risk assessment plan, n) accidental needle stick blood exposure, o) TB, p) MRSA, q) documentation of suspected and actual infections, r) isolation, s) disinfection, t) outbreak procedure, u) cleaning, disinfection and sterilisation guidelines, v) single use equipment, w) waste disposal policy, and x) notification of diseases.</p> <p>There is also a scope of the infection control programme, standards for infection control and infection control preparation, responsibilities and job description, waste disposal, notification of diseases and educational hand-outs.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control co-ordinator has maintained her skills and knowledge of infection control practice through attendance at the PSC infection control nurse peer support day (annually) which includes a variety of speakers. The IC co-ordinator attends two education sessions a year at the DHB.</p> <p>The infection control co-ordinator provides infection control orientation to all new staff. Staff complete infection control questionnaire following orientation. Infection control education is part of the professional nurses and HCA study days that are held annually. The infection control co-ordinator attends the quality and staff meetings and provides topical education which is documented in the meeting minutes.</p> <p>Resident education is expected to occur as part of providing daily cares. There is evidence of consumer and visitor education around influenza vaccines.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>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.</p> <p>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 GP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported to the monthly quality meeting. The meetings include the monthly infection control report and external benchmarking quarterly results as available. Individual resident infection control summaries are maintained.</p> <p>The service utilises an external benchmarking programme which analyses service data on a quarterly basis. Summaries/graphs of these results are feedback to Kandahar and compared with other PSC homes of similar size and service.</p> <p>Information is readily available to staff. Systems in place are appropriate to the size and complexity of the facilities.</p> <p>All infections (and suspected infections) are documented on the infection monthly on line register. The surveillance of infection data assists in evaluating compliance with infection control practices. The staff are kept informed regarding infections, trends, corrective actions and outcomes as sighted in staff meeting minutes.</p> <p>Internal infection control audits are planned and undertaken as scheduled during the year. Hand hygiene audits are conducted randomly.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Low</p>	<p>The PSC restraint minimisation and enabler use policy states that an enabler is the term applied to equipment such as bedrails, "noodles", bed wedges, lap/thigh belts, used to promote the independence, comfort and safety of the resident. The service's practice of the use of 'enablers' does not include a voluntary decision by the resident. The decision for the use of 'enablers' is a clinical decision made by the nursing staff and</p>

		<p>with input from family. This audit has found that the policy does not align with the current standards (link #1.2.3.3). The use of 'enablers' at PSC Kandahar constitutes restraint under the 2008 restraint minimisation and safe practice standards. Therefore, all residents with 'enablers' have been audited as restraint. There are five hospital residents and two dementia residents with restraint. The types of restraint in use include lap belts, bed rails, and T-belts. Advised by the care managers that the intention of the devices is for falls prevention. The service has documentation for consent, assessment, planning and monitoring.</p> <p>The service has a restraint coordinator and 'enabler' registers are maintained for each service area. Documented enabler monitoring occurs for a period of two weeks then is documented in the progress notes each shift. However, entries in progress notes lack sufficient detail in regards to cares provided and specific monitoring interventions (link #2.2.2.1). There is provision for the use of an emergency enabler. Risks associated with the use of enablers have not been identified in the assessment or recorded in the long term care plan for four hospital residents (link #2.2.3.4). Enabler co-ordinators within the PSC group meet twice yearly and have telephone conference resources available. Restraint minimisation is included in the HCA study days.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The enabler coordinator is a registered nurse and she is supported by the care managers of PSC Kandahar. The enabler coordinator has completed restraint training. There is an enabler coordinator job description. The approved restraints/enablers include lap belts, bed wedges, noodles, tray tables, harness, T-belt, and bed rails. These are documented in the restraint policy.</p> <p>Restraint (enabler) use is in consultation/partnership with the family/whanau, the enabler coordinator, registered nurses and care managers.</p> <p>There is provision for emergency restraint (enabler) following consent from family/whanau. Assessments identify specific interventions or strategies to try (as appropriate) before use of restraint. Alternative strategies are documented on the behaviour chart of a resident with challenging behaviour. Staff complete incident forms and report any</p>

		<p>accidents/incidents to the registered nurses and care managers in regards to restraint use and these are discussed at the RN and management meeting and corrective actions initiated. Frequent fallers are identified through the accident/incident data collated. Restraint (enabler) use is considered as a last resort and only implemented in consultation with the family and where resident safety is compromised. Each episode of restraint is monitored at pre-determined intervals (as per the long term care plan) depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated at least six monthly or earlier if required. The restraint monitoring form includes codes for care delivered throughout the restraint episode and this is recorded on the monitoring form. The residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint (enabler). Care plans reviewed of four hospital residents and two dementia residents with restraint (enabler) identified monitoring is documented in the progress notes once per shift (link #2.2.3.4).</p> <p>The enabler coordinator is a registered nurse and she is supported by the care managers of PSC Kandahar. The enabler coordinator has completed restraint training. There is an enabler coordinator job description. The approved restraints/enablers include lap belts, bed wedges, noodles, tray tables, harness, T-belt, and bed rails. These are documented in the restraint policy.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>PA Low</p>	<p>Restraint/enabler assessments are undertaken by the enabler coordinator or registered nurse in partnership with the resident's family/whanau. Restraint assessments are based on information in the initial care assessment, long term care plan, resident/family discussions, RN and care staff observations, accident or incidents, review of clinical risk assessment tools and behaviour assessments. There is a restraint assessment and consent form and this completed in consultation and discussion with the family/whanau and GP. Four hospital resident files and two dementia resident files reviewed with restraint (enablers) evidenced an assessment, consent form and six monthly evaluations were completed. However, there the assessment and subsequent care plan records did not record the risks associated with the use of the restraint in four of four hospital level residents reviewed. The care plans do not include comfort cares and interventions to carry out while restraint</p>

		is in use.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Moderate	<p>A registered nurse in the rest home/hospital is the enabler co-ordinator. She receives advice and input from the registered nurses, care managers, general practitioner, nurse practitioner and family/whanau.</p> <p>The service has an approval process that is applicable to the service.</p> <p>Approved restraints (enablers) include lap belts, bed wedges, noodles, tray tables, harness, T-belt, and bedside rails.</p> <p>Six resident files with restraint were reviewed – four hospital and two dementia residents. Restraints in use for hospital residents included lap belt, bed rails, and bed wedges. One dementia resident had bed rails in place over night and one dementia resident has a lap belt in place while seated. There is evidence that six resident's care plan includes reference to the restraint. New restraint (enablers) are monitored for two weeks and recorded on an enabler monitoring form. Once the decision has been made to continue with the restraint then care staff record in progress notes each shift when the restraint is in use. Progress notes reviewed for four hospital and two dementia residents do not evidence that monitoring has occurred as per the enabler policy regarding monitoring. There is insufficient detail to provide an accurate account of the reasons for use, duration, monitoring and cares provided.</p> <p>Six of six restraint files reviewed had a consent form detailing the reason for restraint and the restraint to be used. Monitoring forms are completed for all new restraint.</p> <p>The service has a restraint/enabler register in each level of care that records sufficient information to provide an auditable record of restraint use.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). Written evaluations are completed by the registered nurses at least six monthly or earlier if required as part of the three monthly care review. Families are included in restraint review as part of the long term care plan review. Individual restraint use is monitored. Records of monitoring</p>

		<p>by care staff in progress notes requires further improvement (#2.2.3.4). Staff advice that they carry out the care required for residents when restraint is in use, however, this is not recorded in sufficient detail. The policy clearly states the timeframes for monitoring and provision of care and comfort measures when restraint is in use which staff were familiar with.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Individual approved restraint (enabler) is reviewed at least three monthly as part of the medical review and three monthly as part of the long term care plan review in consultation with the family/whanau as appropriate. Restraint usage is monitored regularly by the care managers and enabler coordinator. Incident/accidents are reviewed by the care managers. Corrective actions are monitored. Restraint is discussed at all clinical and management meetings. Issues/concerns are discussed at the meetings (minutes sighted). Restraint use is linked to the quality programme. Individual restraint use is monitored and recorded by care staff (with improvements required).</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Low	<p>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. There is an annual staff training programme that is implemented and based around policies and procedures, records of staff attendance and content has been kept (now on-line) and sessions evaluated. Policy reviews are generated by head office and staff are required to read and sign a reading list of any new/reviewed policies. The quality co-ordinator is responsible for document control within the service ensuring staff are</p>	<p>The policy for the use of enablers does not align with the restraint minimisation and safe practice for the 2008 Health and Disability Sector Standards. The medication policy around timeframes for staff for medication competencies does not align with the Ministry of Health medication guidelines. The protocol around head injury neurological observations does not meet current good practice.</p>	<p>Ensure policies and procedures align with current good practice and meet the requirements of legislation.</p> <p>180 days</p>

		kept up to date with the changes		
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	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. All resident accident/incidents are reported on the correct form. There is documentation in the health status summary of all incidents.	There is no evidence of neurological observations for three hospital residents and one dementia care resident following falls with head injury.	<p>Ensure neurological observations are commenced for all falls with head injury.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	Medication charts were reviewed for 18 residents (six rest home, six hospital and six dementia residents). All charts reviewed identified that the GP or nurse practitioner had seen the resident at least three monthly. All medications were signed for and charted appropriately including reasons for use for PRN medication. Medication charts are legible, and up to date. Medication charts have photo ID's and allergies noted.	i) Residents who are assessed as competent to self-medicate (five hospital residents) are given their individual medicine doses by the registered nurse. Residents are left with their medications to take at a time convenient to them. The RN then signs that the resident has taken the medications, however, the nurse has not witnessed the ingestion of the medicines. This practice does not align with facility policy for self-administration; ii) residents with insulin are given the correct doses at the correct time as per the medication order, however, signing for the insulin is not recorded on a separate signing sheet. It is included in the general pre-packed medications signing sheet.	<p>i) ensure correct and safe procedure is followed when administering medications as per facility policy and medicine care guidelines 2011; ii) document insulin doses on separate signing sheets. iii) ensure antipsychotic injections are given as prescribed.</p> <p>30 days</p>

			Specific times and dose are not recorded. Two staff check all insulin prior to administration. iii) one resident on two weekly antipsychotic injections has missed a dose.	
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	Assessment information is gathered from the resident, family, needs assessment service and from risk assessments conducted after admission. A comprehensive nursing assessment is completed on which to base the long term care plan for six of nine resident files reviewed.	<p>i) One hospital resident who was transferred from the dementia unit to hospital level care had a long term care plan written prior to admission. No new assessments were conducted and a new care plan was not written until two months after admission; ii) one rest home respite resident (with frequent prior respite admissions) did not have new risk assessments conducted for the current admission. The service was utilising a previous care plan written in May 2014. The comprehensive assessment was not completed; iii) one dementia level resident had the comprehensive assessment completed after the long term care plan was developed.</p>	<p>Ensure that all assessments are completed and reviewed as per contractual and resident requirements</p> <p>90 days</p>
<p>Criterion 2.1.1.4</p> <p>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</p>	PA Low	The PSC restraint minimisation and enabler use policy states that an enabler is the term applied to equipment such as bedrails, "noodles", bed wedges, lap/thigh belts, used to promote the	The service has assessed and classified all residents with restraint as 'enabler's. This does not align with the 2008 restraint minimisation and safe practice standards. The decision for the	Ensure that all residents with restraint are classified as such to align with current standards and best practice.

independence and safety.		independence, comfort and safety of the resident. The service's practice of the use of 'enablers' does not include a voluntary decision by the resident. The decision for the use of 'enablers' is a clinical decision made by the nursing staff and with input from family. This audit has found that the policy does not align with the current standards (link #1.2.3.3). The use of 'enablers' at PSC Kandahar constitutes restraint under the 2008 restraint minimisation and safe practice standards. Therefore, all residents with 'enablers' have been audited as restraint.	use of 'enablers' has not been a voluntary decision made by the resident or activated EPOA. The reasons for use of 'enablers' for five hospital and two dementia residents constitutes restraint. The policy requires review (as per finding in #1.2.3.3) to align with the current standards and best practice.	90 days
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the</p>	PA Low	<p>Restraint (enabler) assessments are completed for four hospital level residents and two dementia level residents. There is evidence of input from family/whanau and GP. Behaviour assessments and monitoring are completed for two dementia resident files reviewed in relation to restraint. The assessment includes culturally safe practice. The care plans for four hospital and two dementia level residents include the type of restraint in use, reasons for use and monitoring time frames. For two dementia residents the risks associated with the restraint are recorded.</p>	<p>The restraint care plans for four hospital level residents do not include the risks associated with the restraint and the cares and comfort measures required to be implemented when restraint is in use.</p>	<p>Ensure that all restraint care plans detail the individual resident's risks associated with the use of restraint and also details the cares and comfort measures required while restraint is in use.</p> <p>90 days</p>

<p>consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies.</p>				
<p>Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the</p>	<p>PA Moderate</p>	<p>Six resident files with restraint were reviewed – four hospital and two dementia residents. Restraints in use for hospital residents included lap belt, bed rails, and bed wedges. One dementia resident had bed rails in place over night and one dementia resident has a lap belt in place while seated. There is evidence that six resident’s care plan includes reference to the restraint. New restraint (enablers) are monitored for two weeks and recorded on an enabler monitoring form. Once the decision has been made to continue with the restraint, then care staff record in progress notes each shift when the restraint is in use. Six of six restraint files reviewed had a consent form detailing the reason for restraint and the restraint to be used. Monitoring forms are completed for all new restraint. The service has a restraint/enabler register in each level of care that</p>	<p>Progress notes reviewed for four hospital and two dementia residents using restraint do not evidence that monitoring has occurred as per the enabler policy and procedures. There is insufficient detail to provide an accurate account of the reasons for use, duration, monitoring and cares provided.</p>	<p>Provide evidence that monitoring of restraint has occurred at the frequency recorded in policy and procedures and individual care plans 90 days</p>

evaluation of the restraint.		records sufficient information to provide an auditable record of restraint use		
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.4.2</p> <p>Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.</p>	CI	<p>Cultural/treaty training has been provided as part of the Health Care Assistant and RN study days for all staff. Discussions with staff identify that they have responded appropriately to the cultural needs of residents and their whanau. There were Maori residents at the facility on the day of audit. The care of Maori residents were planned with the resident/whanau and is well documented in the long term care plan.</p>	<p>The service aims to be a leader in meeting the needs of the local Maori people requiring full-time care . Cultural and spiritual practice is supported. There are employee guidelines to guide staff in the delivery of culturally acceptable care for Maori residents. The service has access to a cultural advisor with links to local Iwi. The Iwi has recently blessed the facilities and there is ongoing communication between a group of Maori staff and the local Iwi and Kaumatua to co-ordinate Maori health plans in a culturally safe way. Senior Maori healthcare assistants are Kuia within the local Iwi. The families/whanau and residents interviewed state that their cultural needs are being met well and they could not expect more, the staff have exceeded expectations.</p>

<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>CI</p>	<p>RNs and ENs attend two PSC professional study days a year that cover the mandatory education requirements and other clinical requirements.</p> <p>The service identified that English is a second language for a large percentage of their workforce.</p>	<p>The service changed the education system in August to provide a study day that covers all the mandatory education requirements. There is one day per month offered over ten months of the year. This ensures 100% staff attendance for all mandatory education. A physiotherapist was contracted in August 2014 for resident assessments and to provide safe manual handling training for staff.</p> <p>Learning topics have been developed from audit outcomes or improvements identified from accident/incidents. Learning topics are delivered at handovers. Following a medication error staff write up a reflection of the error and present it at handover as a learning exercise for staff. There has been a drop in medication errors as staff reflect on their practice and others learn from them.</p> <p>The service engaged a literacy provider to work with the students (who have English as a second language) to improve their literacy and communication skills. All students graduated recently with a ceremony held at the local Marae and with the Mayor and other dignitaries in attendance. Student evaluations identified an increase in confidence and communications skills were the main benefits gained. Three HCAs interviewed had completed the course and stated they felt more confident and they are now able to communicate effectively with other staff, residents and allied health professionals. Management also stated the staff are much more confident and this is reflected in their daily interactions with staff and residents. As part of the assessment process each student chose a resident to write their life story. One of the life stories was then presented at the person's funeral.</p>
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End of the report.