

# Presbyterian Support Central - Kowhainui Complex

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## 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:

<b>Legal entity:</b>	Presbyterian Support Central
<b>Premises audited:</b>	Kowhainui Complex
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 17 June 2015    End date: 18 June 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	77

# Executive summary of the audit

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

## General overview of the audit

Kowhainui Enliven is part of Presbyterian Support Central and provides rest home and hospital level care for up to 79 residents. On the day of audit, there were 77 residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and general practitioner.

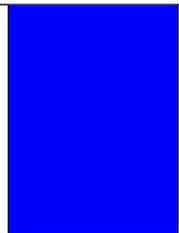
There is a comprehensive orientation programme in place that provides staff with appropriate knowledge and skills to deliver care and support. A quality and risk management programme is well established and embedded into service delivery.

The manager has been in the role for 21 years and is also supported by a clinical nurse manager (registered nurse), quality coordinator and regional manager.

Service delivery was well documented. Comprehensive assessments linked to care plans which were focused around individualised care.

The service has been awarded four continuous improvements (CI) in respect of promoting resident independence, good practice, quality improvements and the activities programme.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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Kowhainui provides care in a way that focuses on the individual resident. There is a Maori Health Plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are implemented to support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with the community.

## 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.		Standards applicable to this service fully attained.
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Kowhainui is implementing the Presbyterian Support Services quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly senior team meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes a summary of incidents, infections and internal audit results. There are human resources

policies including recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

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.

All standards applicable to this service fully attained with some standards exceeded.

A service information pack is made available prior to entry or on admission to the resident and family/whanau. Registered nurses are responsible for each stage of service provision. Assessments and support plans reviewed were developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. The residents' needs, objectives/goals have been identified in the long-term support plans and these have been reviewed at least six monthly or earlier if there was a change to health status. Resident and/or family/whanau and multidisciplinary team have input into the three monthly reviews. Resident files are integrated and include notes by the GP and allied health professionals. The activity programme is resident-focused and provides group and individual activities planned around everyday activities such as gardening, crafts, outings and drives. There are strong community links including 14 volunteers.

There are medicine management policies and procedures in place. Medication is managed in line with current guidelines. The medication charts meet legislative prescribing requirements and are reviewed by the GP three monthly.

The company dietitian reviews the five weekly menus. Food services staff are aware of resident's likes/dislikes and alternative choices are offered.

## 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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Kowhainui is a purpose built facility. The building has a current building warrant of fitness and maintenance is carried out. All rooms are single, personalised, and have an ensuite. There is adequate room for the safe delivery of hospital and rest home level of care within the resident's rooms. Residents can freely access communal areas using mobility aids. There are communal dining areas, craft and recreational areas, and several lounges and seating areas. Outdoor areas and the internal courtyards are safe and accessible for the residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely throughout the facility. The cleaning service maintains a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service currently has a restraint-free environment. The service has policies and procedures to support the use of enablers. There is an enabler co-ordinator for the service, who is the care manager in the hospital (RN). There were 12 bedrails and three lap belts identified as enablers on the register. Consents (voluntary) and assessments for all residents with enablers were up to date. Risks associated with the use of enablers have been identified in the assessment. Restraint minimisation, enabler use and challenging behaviour training are included in the training programme.

## 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 programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (clinical nurse manager) is responsible for coordinating education and training for staff. There are a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

## 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)
<b>Standards</b>	2	43	0	0	0	0	0
<b>Criteria</b>	4	89	0	0	0	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>PSC Kowhainui has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission, which includes the Code. Staff receive training about abuse and neglect and advocacy services that includes the Code, at orientation and as part of the two yearly core study days (link 1.2.7). Interview with six healthcare assistants (three rest home and three hospital) demonstrate an understanding of the Code. Residents interviewed (three rest home and five hospital) and relatives (five rest home and five hospital) confirm staff respect privacy, and support residents in making choice where able.</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. The consent forms also state the resident may withhold or decline to consent for any specific procedure. The staff interviewed (six health care assistants</p>

		<p>(HCA) three rest home and three hospital), three registered nurses (RN) (three rest home and three hospital) and the care manager (CM) were knowledgeable in the informed consent process. Nine resident files sampled (five hospital and four rest home) had appropriately signed resuscitation forms.</p> <p>D13.1 There were nine admission agreements sighted and all signed appropriately.</p> <p>D3.1.d Discussion with eleven families (five hospital and six rest homes) identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent.</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>	FA	<p>Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the manager and clinical nurse manager confirm practice. Interviews with residents confirm that they are aware of their right to access advocacy. A local advocate attends the resident meetings.</p> <p>D4.1d Discussions with family members confirm that the service provides opportunities for the family/EPOA to be involved in decisions.</p> <p>ARC D4.1e The resident files reviewed included information on residents' family/whānau and chosen social networks.</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>	FA	<p>D3.1h Interview with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility.</p> <p>D3.1.e Discussion with six healthcare assistants, and three activities staff, 10 relatives and 11 residents confirm residents are supported and encouraged to remain involved in the community and external groups.</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>	<p>FA</p>	<p>There is a complaints policy to guide practice and this is communicated to resident/family. The manager leads the investigation and management of complaints (verbal and written). There is a complaints register that records activity. Complaints are discussed at the monthly senior team meeting and at the hospital/rest home meetings. Complaint forms are visible around the facility on noticeboards. There was one documented complaint for the 2014 year in regards to care and communication. Follow up letters, investigation and outcome was documented. Discussion with residents and relatives confirmed they were aware of how to make a complaint. D13.3h. a complaints procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There is a welcome pack that includes information about the Code and with the opportunity to discuss prior to, and during the admission process with the resident and family. Large print posters of the Code and advocacy information are displayed through the facility. The monthly resident circle meetings also provide the opportunity for residents to raise issues (minutes sighted). A resident advocate is involved in the meetings. Residents interviewed and relatives inform information has been provided around the Code. The manager and clinical nurse manager stated they have an open door policy for concerns or complaints.</p> <p>D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, CoR pamphlet, advocacy and Health &amp; Disability Commission. The manager, clinical nurse manager and registered nurses described discussing the information pack with residents/relatives on admission.</p> <p>D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	<p>FA</p>	<p>There are policies in place to guide practice in respect of independence,</p>

<p><b>Respect</b></p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>privacy and respect. A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Resident files were noted to be stored out of sight. Staff could describe aspects of abuse and neglect. All 10 relatives interviewed stated that staff were respectful.</p> <p>A resident and relative satisfaction survey is completed annually (last completed September 2014). Overall outcome was rest home residents 84.57%, relatives 94.58% and hospital residents 82.94% and relatives 91.29%. Outcomes discussed at resident circle meeting.</p> <p>Kowhainui has demonstrated a commitment to promoting independence and developing a service that reflects the wishes of the consumer, this can be seen through the movement towards becoming an Eden registered facility. Based on implementation of this initiative a continued improvement has been awarded against criterion level. The initiatives implemented around Eden have included a review process, quality improvement action planning and a change for residents as a result. The Eden philosophy is seen to be an integral part of daily operations.</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. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities.</p> <p>D4.1a: Nine resident files reviewed identified that cultural and/or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan. This includes cultural, religious, social and ethnic needs. Interviews with residents confirm their values and beliefs were considered.</p> <p>D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.</p>
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<p><b>Standard 1.1.4: Recognition Of Māori Values And Beliefs</b></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>The Presbyterian Support wide Māori Health plan has been reviewed and updated through the Māori Health plan Wellington Group. The service has access to a cultural advisor with links to local Iwi.</p> <p>A3.2 Kowhainui has a site specific Māori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a cultural safety policy to guide practice including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. There are currently five Māori residents at Kowhainui. Interviews with two residents confirmed that the service provides a culturally safe service.</p> <p>The service identifies the need for staff to be trained in delivering appropriately cultural services. Cultural/treaty training has been provided as part of the Health Care Assistant and RN study days for all staff.</p> <p>Special events and occasions are celebrated and this could be described by staff.</p>
<p><b>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</b></p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The resident and family are invited to be involved in care planning. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews are scheduled and occur to assess if needs are being met. Discussions with 10 relatives inform values and beliefs are considered. Discussion with residents confirms that staff take into account their culture and values.</p> <p>D3.1g The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whanau.</p> <p>D4.1c Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.</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 &amp; 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. Understanding the code of conduct and information technology (IT) usage policy is signed as part of orientation. Interview with six healthcare assistants could discuss professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>Kowhainui has a suite of policies and procedures that are updated as necessary. There is a quality improvement programme that includes performance monitoring against clinical indicators separated into service type – i.e. rest home and hospital. Kowhainui is benchmarked against other Presbyterian facilities and other facilities across NZ and Australia. 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. Policies and procedures cross-reference other policies and appropriate standards. RN's are encouraged and supported to continue education within the organisation. Health care assistants are supported to complete Career Force or unit standards.</p> <p>Kowhainui is implementing the Eden Philosophy with achievement of seven (of 10) principles and currently working towards achieving the remaining three Eden Principles. Interview with six healthcare assistants informed an understanding of the Eden principles. Eden photos posters on notice boards and domestic pets.</p> <p>ARC A2.2 Services are provided at Kowhainui that adhere to the health &amp; disability services standards.</p> <p>ARC D1.3 All approved service standards are adhered to.</p> <p>ARC D17.7c There are implemented competencies for healthcare assistants and registered nurses including but not limited to: insulin administration, medication, manual handling.</p> <p>Residents and relatives interviewed were positive about the care they</p>

		receive. Interview with six healthcare assistants (who work across both areas) inform they are supported by the RN's and management team.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an open disclosure policy. Discussions with eight residents and 10 family members confirmed they were given time and explanation about services on admission. Resident meetings occur monthly and the manager and care manager have an open-door policy.</p> <p>Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twenty incident forms reviewed from May/June identify family were notified following a resident incident. Interview with six caregivers (who work across both services) and three RN's inform family are kept informed.</p> <p>D16.4b The residents and relatives interviewed confirmed family have been informed when the resident health status changes. The service has policies and procedures available for access to interpreter services and staff interviewed were able to describe the process.</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 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>'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>D 13.3 Nine resident admission agreements sighted were 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.</p>

<p><b>Standard 1.2.1: Governance</b></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>Enliven PSC have a Strategic Framework. Kowhainui has a 2014-2015 Business Plan and a mission and vision statement defined. The Business Plan outlines a number of goals for the year, each of which has defined objectives against quality, Eden and health and safety. For example a goal is “client and resident quality of life is enhanced through assured quality of service”; a quality objective being: client goals met 95% of the time; and Eden objective “achieving principles 6, 8 and 9. Progress towards goals (and objectives) is reported through the manager reports taken to the monthly senior team meeting and discussed at staff meetings.</p> <p>Kowhainui Enliven is part of Presbyterian Support Central and provides rest home and hospital level care for up to 79 residents. On the day of audit, there were 39 rest home residents and 35 hospital level residents. There are 13 dual purpose beds. There was one respite resident in the rest home and one in the hospital and one YPD resident.</p> <p>The manager has been in the role for 21 years and has a Dip in Business Management. The manager reports to a regional manager who oversees six facilities. The manager is also supported by a clinical nurse manager (registered nurse). The senior management team attend four full days peer support training days each year.</p> <p>ARC,D17.3di The manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.</p>
<p><b>Standard 1.2.2: Service Management</b></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>There is a registered nurse on duty 24/7. The clinical nurse manager undertakes the manager’s role in the absence of the manager. Support is available from the regional manager.</p> <p>D19.1a A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI 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>FA</p>	<p>PSC has an overall Quality Monitoring Programme (QMP) and participates in QPS quarterly benchmarking programme - implemented at Kowhainui. The service has a quality coordinator that works fulltime.</p> <p>The senior team meeting acts as the quality committee meetings and they meet 2 x monthly. Information is fed back to the monthly clinical focussed meetings and unit staff meetings. A range of other meetings are held at the facility. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness.</p> <p>Feedback on monthly accident and incidents are provided to all meetings. The service has linked the complaints process with its quality management system – including QPS benchmarking programme and feedback through the quality and staff meetings. There is an infection control register documenting monthly activity. A monthly infection control report is completed and provided to quality meeting. Again, infections are part of the QPS benchmarking programme. Infections are also being documented on an electronic database. Feedback is provided to staff through memos that include outcomes and improvements. The service has a health and safety management system and this includes a health and safety rep that has completed health and safety training. Monthly reports are completed and reported to meetings and at the quarterly health and safety committee. Health &amp; Safety meetings include identification of hazards and accident/incident reporting and trends. Emergency plans ensure appropriate response in an emergency. Kowhainui is currently restraint free with enablers only in use (link 2.1).</p> <p>The service has policies and procedures to provide 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. 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. New/updated policies/procedures are generated from head office. The quality co-ordinator is responsible for document control within the service; ensuring staff are kept up to date with the changes.</p>

		<p>There is an organisational staff training programme that is being implemented and based around policies and procedures (link 1.2.7).</p> <p>The Quality Monitoring Programme (QMP) includes an internal audit programme that is being implemented and where a result does not meet the 85% threshold, a re-audit is completed for example at Kowhainui: wound management (completed April (67.5%), re-audit June (100%). Corrective actions are evaluated.</p> <p>An annual resident and relative satisfaction survey has been completed as per company schedule which included an analysis. D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.</p> <p>D19.2g Falls prevention strategies such as sensor mats and individual review of residents who fall.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>FA</p>	<p>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.</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>Senior team meetings and clinical focussed meeting minutes include a comprehensive analysis of incident and accident data and corrective actions. A monthly incident accident report is completed which includes an analysis of data collected. This is provided to staff.</p> <p>Twenty incident forms were reviewed across the rest home/hospital from May and June. All identified follow up assessment by a registered nurse including neuro observations for those residents that had a fall and hit their head.</p> <p>The monthly reports provided to staff via meetings, and on staff notice boards include the external benchmarking indicator results that includes analysis of manual handling injuries, skin tears, resident falls, resident</p>

		<p>accidents, medication errors, and staff accidents</p> <p>Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></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>There is a human resources policies folder including recruitment, selection, orientation and staff training and development. 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>Ten staff files were reviewed clinical nurse manager, three registered nurses, three caregivers, one cook, diversional therapist and cleaner. Each folder had a file checklist and documentation arranged under personal info, correspondence, agreement, education and appraisals. Annual appraisals have been completed and up to date.</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 were sighted. There is an implemented specific RN orientation book and RN competencies are completed. RNs and ENs attend two PSC professional study days a year that cover the mandatory education requirements and other clinical requirements – a schedule is available to see planned attendance. Medication competency is current for staff administering medications, with the exception of the care manager and this is an area of improvement against training. The physiotherapist provide annual manual handling training.</p> <p>Attendance at core study days is also a requirement for HCAs. The attendance tracking sheet reviewed as part of the audit identifies healthcare assistants are monitored to ensure they are attended.</p> <p>External education and 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. Literacy and numeracy training is offered. Of the 53 caregivers, 25 have Level III</p>

		<p>qualification, five have Level II qualification, five are studying at Level II and five are registered nurse students.</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 caregivers. 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. There is a first aid trained staff member on every shift.</p> <p>There is now an Enliven wide trainer, supported by a part time training administrator. This has enabled streamlining of booking for training programmes which are delivered at venues central to those due to attend. Kowhainui is a host home for the nursing clinical and professional days. Kowhainui was the trial site for the first of the revised mandatory training sessions.</p> <p>Enliven wide training is now guided by a training advisory group made up of managers and clinical nurse managers. The Kowhainui CNM is on this group.</p> <p>Since 2014, a third clinical and a third professional study day has been added to allow additional focus on clinical issues, e.g. recognising frailty, and time for quality improvement systems and processes to be discussed.</p> <p>First year of practice (FYOP) – In 2015 Enliven has a formal programme to support three supernumerary first year of practice nurses as they develop their practice. The programme is led by one of the Nurse Consultants. Kowhainui has one of the FYOP nurses and has hosted a second for practice experience.</p> <p>The Enliven PDRP programme has been refined. The PSC nurse consultants are providing support (workshop) and advice to Kowhainui as required. It is intended to have the programme submitted to Nursing Council for approval by the end of July 2015. At Kowhainui they are having fortnightly meetings to provide peer support for RNs and ENs working on their PDRP.</p>
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<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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.</p> <p>Manager and clinical nurse manager work full time, Monday through Friday. There is a registered nurse rostered in the rest home 0900 – 1440 across seven days a week.</p> <p>There are two registered nurses rostered in the hospital am and pm shifts. There is one registered nurse across the facility on night shift; the RN is supported by three caregivers.</p> <p>Interview with six caregivers informs there is sufficient staff to meet needs.</p>
<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>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within required timeframes into the resident's individual record. An initial care 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 locked staff area. Care plans and notes are legible. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. D7.1 Entries are legible, dated and signed by the relevant healthcare assistant or registered nurse including designation.</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>	<p>FA</p>	<p>All residents are assessed prior to entry for rest home or hospital level of care. A placement authority form is sent to the receiving facility. The clinical nurse manager is responsible for the screening of residents to ensure entry has been approved. A pre-admission checklist ensures the potential resident and family are shown around the facility and introduced to staff. An information booklet is given out to all</p>

		<p>residents/family/whanau on enquiry or admission.</p> <p>The clinical nurse manager (interviewed) was able to describe the entry and admission process. The registered nurse or clinical nurse manager completes all admission documentation and relevant notifications of entry to the service. Eleven residents (five rest home and six hospital) and ten relatives (five rest home and five hospital) interviewed stated they received all relevant information prior or on admission. The GP is notified of a new admission.</p> <p>D13.3 Nine signed admission agreements were sighted. The admission agreement reviewed aligns with a) -k) of the ARC contract.</p> <p>D14 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>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 clinical nurse manager interviewed described the documentation (resuscitation form, medication chart, resident risk summary, progress notes, and GP notes) and nursing requirements as per the policy for discharge and transfers. Any previous discharge summaries that are relevant are also copied and sent with the transfer documents. Transfer documentation was sighted in a resident's file following recent transfer back to the facility from hospital. An end of service checklist is completed on transfer or death of a resident.</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>FA</p>	<p>There are policies and processes that describe medication management that align with accepted guidelines. The rest home and hospital areas have separate medication rooms. The supplying pharmacy delivers all pharmaceuticals, monthly regular and 'PRN' Douglas medico packs. The returns are stored safely until collected. An RN checks all medications on delivery and completes a medication audit form. Any discrepancies are fed back to the supplying pharmacy. All as required (PRN) medication supplies are checked monthly. The RNs, EN and senior HCA's administering medications undergo a medication competency. RN's and EN's attend syringe driver education at the hospice.</p>

		<p>There is a weekly check of stock and emergency equipment. All eye drops in use are dated. There are no standing orders. There are two self-medicating residents who have completed their competency to self-administer medication.</p> <p>Eighteen resident medication charts sampled identified all charts had photo identification and allergies/adverse reactions noted, and PRN medications prescribed correctly with indications for use. There is a staff alert form used for changes in medication charts. Other labels used include "duplicate name". There were no gaps on the medication signing sheets.</p> <p>D16.5.e.i. 2, The 18 medication charts included three monthly GP reviews.</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>Food services policies and procedures manual is in place. The hotel services manager is responsible for the food services. 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 monthly and when all the PSC cooks meet annually. The cooks use an IT automatic ordering system that is linked to the recipes, menus and number of meals required. Recipes are available on line as well as "specials" week to celebrate special events. There is a vegetarian menu available and a number of ethnic recipes if required. Any changes to the menu are recorded and exceptions reported to the hotel services manager. Resident birthdays and special occasions are catered for. All residents have a dietary requirements/food and fluid chart completed on admission.</p> <p>The cook maintains a folder of resident's dietary requirements that include likes/dislikes. Alternative choices are offered. The cook is informed of dietary changes and any residents with weight loss. Dietary needs are met including normal, pureed meals and finger foods. Specialised utensils and lip plates are available as required. Residents and relatives interviewed confirm likes/dislikes are accommodated and alternative choices offered. Daily hot food temperatures are taken and recorded for each meal. A portable bain marie is used to deliver foods to the hospital dining room. Holding temperatures are taken. Fridge and</p>

		<p>freezer temperatures are recorded. Dry foods in the pantry are dated and sealed. Perishable foods in the chiller and refrigerators are date labelled and stored correctly. The kitchen has a good work flow with a separate dishwashing area, preparation, cooking, baking and storage areas. The chemicals are stored safely. The chemical supplier completes quality control checks on the sanitizer. Safety data sheets are available and training provided as required. Personal protective equipment is readily available and staff observed to be wearing hats, aprons and gloves.</p> <p>D19.2. The hotel services manager has submitted for marking the final paper in the national certificate in catering services. Staff have completed training in food safety.</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>	FA	<p>The service has an accepting/declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there were no beds available, or the service could not provide the level of care or the acceptance of an admission could potentially affect other residents.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All resident files sampled evidenced an initial assessment and support care plan. Relatives and residents advised on interview that assessments were completed in the privacy of their single room.</p> <p>A range of assessment tools are available for use on admission if applicable including (but not limited to); a) nutritional and fluid assessment, b) falls risk (adapted from Morse), c) moving and handling assessment, d) braden pressure area risk assessment, e) continence and bowel assessment, f) pain assessment, g) wound assessment, h) skin assessment, and i) InterRAI. The diversional therapist (DT) completes an activity assessment. Assessments were noted to be completed on resident files reviewed and linked to long term care plans</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>The RN develops the long term support plan from information gathered over the first three weeks of admission. The resident support plan has categories of care as follows: hygiene and grooming, skin and pressure area care, elimination, mobility, nutrition and fluids, rest and sleep, communication (ability to use call bell, eyesight, memory, behaviour and mood), loneliness (companions), helplessness (socialisation), spirituality/faith and culture, medical (includes medication and pain management).</p> <p>The support plans reviewed reflected the outcomes of risk tool assessments. Interventions clearly described support required. Each resident file sampled had a risk summary form at the front of their file detailing the resident's medical problems and alerts such as high falls risk. There was documented evidence of resident/relative/whanau involvement in the support planning process.</p> <p>Short term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short term care plans are templated for chest, urinary and ear infections, nutritional needs and wounds. Short term care plans sighted included management of: UTI, chest infection, eye infection, skin infection, wounds, nutritional requirements for weight loss and unusual/escalating behaviour. Short term care plans reviewed had been evaluated at regular intervals.</p> <p>Medical GP notes and allied health professional progress notes are evident in the residents integrated files sampled.</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>Residents' support plans are completed by the registered nurses. When a resident's condition alters; the registered nurses initiate a review and if required, GP (interviewed) or specialist consultation.</p> <p>D18.3 and 4 Dressing supplies are available and the treatment rooms were well stocked. All staff report that there are adequate continence supplies and dressing supplies. There are adequate pressure area resources. Specialist continence advice is available as needed through the DHB and the continence product representative. Behaviour management is described in the unusual or escalating behaviour</p>

		<p>management plan which is reviewed by the multidisciplinary team (GP, RN, DT) three monthly. Behaviour monitoring forms are used (sighted) which describes types of behaviour, possible triggers and interventions. The GP initiates any specialist referrals to the mental health services. A health status summary held in the resident's record records any significant events, investigations, GP visits and outcomes.</p> <p>Nineteen wound care plans were reviewed. The GP (interviewed) is notified of all chronic and non-healing wounds. There is evidence of the wound care specialist nurse being involved in chronic, non-healing wounds. All wound care plans reviewed (nine rest home and ten hospital) had well documented wound progress notes, wound assessments, wound management plans and evaluations. Of the files reviewed there were short term care plans in place for minor wounds and skin tears and complex and chronic wounds were included in the long term support plans. Pain management plans were in place for two of the files reviewed, and there was evidence of regular pain relief being administered and then reviewed for efficacy.</p> <p>Behaviour management is described in the unusual or escalating behaviour management plan which is reviewed by the multidisciplinary team (GP, RN, DT) three monthly. Behaviour monitoring forms are used (sighted) which described types of behaviour, possible triggers and strategies for de-escalation. The GP initiates any specialist referrals to the mental health services.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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>CI</p>	<p>The service employs a diversional therapy (DT) team leader who works full time and has 21 years' experience in the DT field. The DT team leader leads a team of three (two DT's, and one recreational officer) to provide activities across the rest home, hospital, day-care and villas. The DT team leader is an Eden associate/driver for the Eden philosophy. The organisation has achieved accreditation of seven Eden principles. There is a set activity programme across the facility that is resident focused and is planned around meaningful everyday activities such as gardening, baking, reminiscing, feeding birds, assisting the hairdresser, dusting, tidying drawers and making own beds (if able). A retired guide dog visits Monday to Friday. The programme is supported by 14 volunteers.</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>The files samples evidenced three monthly (hospital) and six monthly (rest home) MDT evaluations of the support plan. The resident/family interviewed advised that they are notified of the reviews and invited to attend. The long term support plans reviewed evidenced that the support plan was amended with each review if there were changes identified. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts are evidenced in use. Short term care plans reviewed were evaluated regularly with problems resolved or added to the long term support plan if an on-going problem.</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>Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to; needs assessment co-ordination service, psycho-geriatrician, physiotherapist, dietitian, urology, eye clinic, dermatology, and orthopaedics and wound care specialist nurse.</p> <p>There is evidence of GP discussion with families regarding referrals for treatment and options of care.</p> <p>D16.4c There was evidence of a rest home resident re-assessed for hospital level of care and a recent referral to the psychogeriatric team for re-assessment for higher level of care.</p> <p>D 20.1 Discussions with the clinical nurse manager identified that the service has access to nursing specialists such as wound, continence, palliative care nurse, dietitian, speech language therapist, occupational therapist, psychiatric nurse and other allied health professionals.</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</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 chemicals supplies are kept in locked cupboards in service areas. A chemical spills</p>

<p>substances, generated during service delivery.</p>		<p>kit is available. The contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. All infectious material is double bagged. Approved containers are used for the safe disposal of sharps. Personal protective equipment (gloves, aprons, goggles) are readily available to staff.</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 building holds a current building warrant of fitness which expires 22 June 2015. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes. Hot water temperatures are monitored.</p> <p>The maintenance person is a contractor and is employed 40 hours per week and is available for emergencies after hours. Preferred contractors are available 24/7. The maintenance person carries out minor repairs and maintenance, building maintenance as per the schedules and maintains the grounds. The maintenance request book is checked and signed off as requests are actioned. Building warrant of fitness checks are carried out according to the schedule and defects rectified. Electrical equipment is tested and tagged. Clinical equipment is calibrated annually.</p> <p>Wide corridors allow for easy access to communal areas and promote independence for residents with mobility aids. There is a rest home dining room and a hospital dining room, craft room, library and multiple small lounges areas for quiet activities and private meetings with family/visitors and an on-site chapel. There are adequate storage areas for hoist, wheelchairs, products and other equipment.</p> <p>The buildings grounds and gardens are well maintained and able to be accessed safely by residents and have wheelchair access to the outdoors. There is seating and shaded areas available. There are internal courtyard with raised gardens and a kitchen garden. There is a designated internal smoking area.</p> <p>ARC D15.3 The staff interviewed stated that they have all the equipment referred to in support plans necessary to provide care, including hoists (checked April 2015), pressure relieving mattresses and cushions, transfer belts, slide sheets, chair scales (calibrated April 2015 ) wheelchairs, electric beds, sensor mats, gloves, aprons and masks.</p>

<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></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>	FA	<p>All resident rooms are single with hand basins and ensuite. There are adequate communal toilets and shower rooms. The ensuite have appropriate flooring and handrails. There are vacant/occupied signs and privacy locks. Call bells are available in all toilet/shower areas.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident rooms in all the facility are of an adequate size for rest home or hospital level of care. The bedrooms allow for the resident to move about the room independently with the use of mobility aids. The bedrooms rooms are spacious enough to manoeuvre hoists and hospital level lounge chairs. The bedrooms have wide doors for ambulance or bed entry/exit. Residents and their families are encouraged to personalise the bedrooms as viewed. Residents interviewed confirm their bedrooms are spacious and they can personalise them as desired.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The facility has separate rest home and hospital dining areas with open plan lounge rooms. Seating is placed appropriately to allow for groups and individual's to relax or take part in activities. The wide corridors are light and spacious and have seating and small tables placed to create other lounging areas. Residents were observed safely moving between the communal areas with the use of their mobility aids. There is adequate space within the hospital communal areas for the easy manoeuvre of specialised lounge chairs. There is a large recreational area with a bowling table.</p>
<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All personal clothing and laundry is laundered on site. There is a dedicated laundry person seven days a week. There is a defined clean and dirty area of the laundry and an entry and exit door. The laundry is well equipped and the machinery is regularly serviced.</p> <p>Adequate linen supplies are sighted, and afternoon HCA's deliver personal clothing to the rooms. Chemicals are stored in a locked chemical room. There are two cleaners on duty each day. The cleaner's</p>

		cupboard containing chemicals is locked. Cleaner's trolleys are well equipped. All chemicals have manufacturer labels. Laundry and cleaning staff are observed to be wearing appropriate personal protective equipment. The environment on the day of audit is clean and tidy. The residents interviewed are satisfied with the cleanliness of the communal areas and their bedrooms. There is a daily and monthly room clean schedule.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan (letter dated 27 May 2004). Fire evacuations are held six monthly and the last drill was completed 15 April 2015. There is staff across 24/7 with a current first aid certificate. There is a civil defence and emergency plan in place. The civil defence kit is readily accessible. The facility is well prepared for civil emergencies and has emergency lighting, a store of emergency water and a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Hoists have battery back-up. Oxygen cylinders are available. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas with indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells and residents interviewed stated their bells were overall answered in a timely manner.  D19.6 There are emergency management plans in place to ensure health, civil defence and other emergencies are included.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All resident rooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The facility is heated with gas radiator heating and kept at a comfortable temperature. Residents and relatives interviewed confirm the environment and the bedrooms are warm and comfortable.

<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 an external benchmarking system in place and summaries of these results are fed back through the senior team, clinical and staff meetings. The scope of the infection control programme policy and infection control programme description is available. There is an implemented infection control programme that is linked into the risk management system. The infection control coordinator is clinical nurse manager (registered nurse) and she provides a monthly report to the staff. The senior team meeting and the governing body are responsible for the development of the infection control programme and its review.</p> <p>Staff are informed about infection control practises and reporting. Suspected infections are confirmed by laboratory tests and results are collated monthly. There are policies and procedures in place around when an outbreak of infection occurs. There is evidence (signage) of preventative measures in place to prevent resident exposure to infectious diseases such as Norovirus.</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>Infection control meetings are combined with senior team meetings. The infection control coordinator has completed a level 5 IC certificate. The facility also has access to an infection control nurse specialist, public health and GP's</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 implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>D 19.2a The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. The infection control policies and procedures are developed and reviewed by an external infection control specialist.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control</p>	<p>FA</p>	<p>The infection control co-ordinator has maintained her skills and knowledge of infection control practice through attendance at PSC training. The infection control co-ordinator provides infection control</p>

<p>to all service providers, support staff, and consumers.</p>		<p>orientation to all new staff. Infection control education is part of the professional nurses and HCA study days that are held annually. Memos are also provided to staff around IC issues/concerns. Resident education is expected to occur as part of providing daily cares.</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. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP 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 senior team meeting, clinical focused meeting and HCA meetings. The meetings include the monthly infection control report and external benchmarking quarterly results as available. Individual resident infection control summaries are maintained. All infections are documented on the infection on-line register monthly. The surveillance of infection data assists in evaluating compliance with infection control practices. There is documented evidence of corrective actions established as a result of increase of infections, i.e. increase in rest home UTIs over summer included increasing fluid rounds.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service currently has a restraint-free environment. The service has policies and procedures to support of the use of enablers. The organisation is currently reviewing their process around restraint and the amended policy is in draft. The policy meets the intent of the restraint minimisation standards. There is an enabler co-ordinator for the service, who is the care manager in the hospital (RN) with a signed job description. There is currently 12 bedrails and three lap belts identified as enablers on the register. Consents (voluntary) and assessments for all residents with enablers were up to date in the enabler folder.</p> <p>Documented enabler monitoring occurs for a period of two weeks then is documented in the progress notes each shift. The enabler is reviewed</p>

		<p>three monthly. There is provision for the use of an emergency enabler. Risks associated with the use of enablers have been identified in the assessment. Three files reviewed of residents with enablers had identified risks/interventions clearly documented within the resident care plan. Restraint minimisation and enabler training is included in the health care assistants study days and is provided by the enabler coordinator as part of the orientation process. Restraint minimisation and enabler training is also included annually in the core clinical training days for RNs and ENs at an organisational level. Enabler use is discussed and evaluated at the senior team meetings.</p>
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## Specific results for criterion where corrective actions are required

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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.

No data to display
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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 1.1.3.6</p> <p>Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.</p>	CI	<p>PSC has an overall quality (and strategic) framework that Kowhainui has used to progress quality initiatives. The service continues to progress towards the goal of becoming an Eden registered home. A review of documentation, interviews with residents, relatives and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents. Individualised care plans include a section to address loneliness, helplessness, and boredom.</p>	<p>Kowhainui is progressing on the Eden journey having achieved 7 (of 10) Eden principles and are working towards achieving the remaining three Eden principles and becoming a fully “Edenised” home. Eden philosophy underpins projects and initiatives the service develops. Interview with six healthcare assistants describe how choice is incorporated into resident cares. Initiatives have been developed around the implementation of the Eden philosophy. Interviews with residents and family members were positive about the care provided. The service has three cats, a dog and budgies. Residents help look after and feed the animals. Residents have been choosing new furniture when needed including material for the new dining chairs. A few residents have roles in the facility including delivering the daily newspaper. There is a resident circle group (meeting) that provides an opportunity to discuss</p>

			<p>concerns, interests, and become involved in the day-to-day running of the facility. Residents and families have been invited to business planning workshops. Progress related to the Eden journey is documented and evaluated annually. As part of the evaluation, volunteers, staff and residents provide feedback. The last evaluation from the residents meeting stated 'that living here creates a good balance between being independent and able to make own choices'. Once initiative was around the introduction of the breakfast club and breakfast being at flexible time. This was evaluated and residents enjoy being involved and the changes made.</p>
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	<p>CI</p>	<p>Kowhainui has a suite of policies and procedures that are updated as necessary. There is a quality improvement programme that includes performance monitoring against clinical indicators separated into service type – i.e. rest home and hospital. Kowhainui is benchmarked against other Presbyterian facilities and with an external benchmarking programme. 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. Policies and procedures cross-reference other policies and appropriate standards. RN's are encouraged and supported to continue education. Health care assistants are supported to complete Career Force. Enliven wide training is now guided by a training advisory group made up of managers and clinical nurse managers. The CNM at Kowhainui is on this group.</p> <p>Enliven homes are moving from a Care Manager model to a Clinical Nurse Manager supported by Clinical Nurse Coordinators model. This is to</p>	<p>The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction.</p> <p>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. Access to policies and forms has been made easier by an A-Z sorting of key words, which is available on the home page of the PSC intranet. This brings up any related documents to the search topic.</p> <p>The policy review process is now inclusive of</p>

		<p>increase clinical skills and knowledge and have accountability for quality owned at all levels. Kowhainui still in transition from the old to the new model and has a Clinical Nurse Manager and a Care Manager as well as a Quality Coordinator.</p> <p>Meeting structures have been reviewed in order to ensure an efficient flow of information with the appropriate attendees for the topics. The home senior team has agenda items which are addressed on a rotating basis on alternate meetings.</p> <p>Kowhainui has achieved seven (of 10) Eden principles and they are working towards achieving the remaining three Eden Principles and becoming a fully "Edenised" home.</p>	<p>reduction in the number of separate documents on the same topic, in favour of one document with an index approach, e.g. infection control.</p> <p>There is now an internal corrective action form where recommendations, findings and remedial actions from all sources, e.g. complaints, internal and external audit results, incident and accident analysis, can be found in one place for monthly review by the home senior team. There is a "what's new" folder kept in the staff room which contains new policies/key information for staff. Notices to staff are also provided through memos (attached to staff payslips) for any specific information that needs to be addressed e.g. internal audits or staff meeting and "Issue based" reporting.</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. A review of the last benchmarking quarter around clinical indicators was noted to have improved around pressure areas, falls in the hospital, infections, and skin tears.</p> <p>A quality improvement was initiated as a result of the resident satisfaction survey in regards to meals. The service continues to monitor and evaluate the temperature of meals to improve satisfaction. The recently redecorated dining room with heat pump keeps the room at a constant temperature during the colder weather. The evaluation completed identified that the improvement of the environment also has improved the overall "dining experience". Following feedback from residents, they have also increased the fresh food options for light meals (i.e. reducing use of processed foods) and diversified the meals to</p>
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			<p>include meals that would appeal to a broader ethnic range.</p> <p>This audit also identified comprehensive clinical documentation. There was a good link between wound care management and regular pain assessments. Comprehensive assessments were well linked to individualised care. Caregivers interviewed were very familiar with the content of the care plans and individualised care.</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>There is a comprehensive quality and risk management process in place. The service monitoring programme includes infection control, quality improvement, health and safety, service delivery, resident rights, managing service delivery, emergency and human resources. Monitoring in each area is completed monthly.</p> <p>The service completes an internal audit for each area which results in a report that identifies criteria covered and achievement, a general summary of the audit results, key issues for improvement and an action plan for resolution. Meeting minutes and reports are provided to the senior team meeting and actions are identified in minutes and on the QI form, are signed off and reviewed for effectiveness. Corrective actions are implemented and evaluated and internal audits are re-audited as necessary. Improvements were sighted for internal audits that had been re-audited e.g.: Meaningful activities audit 83% hospital / 53% rest home. After implementation of corrective actions and feedback from residents, the re-audit identified improvements to 86% and 87%. Benchmarking includes monthly analysis and corrective actions completed by the quality coordinator. The cleanser (from the external benchmarking</p>	<p>Having fully attained the criterion the service can in addition, clearly demonstrate a review and analysis process of all quality data which is gathered from key components of service which is benchmarked against previously collected data from both internal and by outside agencies. Corrective planning is monitored for effective outcomes. Many corrective actions are written up as quality improvements. In 2014 the Enliven Excel based registers were transferred to a database environment which enabled Kowhainui to sort all entries, e.g. incidents, infections, falls by resident. This has been utilised to proactively identify resident of concerns and inform support and communication plans for those residents. Benchmarking for rest home and hospital is collected and an analysis is completed. As a result of identify residents at risk and strategies implemented; this quarter has identified a decrease in falls by 26% in the hospital in the last quarter. Resident complaints are down and below the mean in the rest home and hospital. This has been maintained. The resident circle group is an avenue for discussing concerns and being involved in decisions at Kowhainui.</p>

		<p>programme) also completes an analysis and suggests possible improvement ideas. These are implemented and improvements noted, e.g. pressure areas have improved in the last quarter and these were identified at Kowhainui as below the mean against other providers.</p> <p>Meeting minutes, graphs, benchmarking reports are provided to staff.</p>	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service employs a diversional therapy (DT) team leader who works full time and has 21 years' experience in the DT field. The DT team leader leads a team of three (two DT's, and one recreational officer) to provide activities across the rest home, hospital, day-care and villas. The residents enjoy inter-home picnics, preschool visits, reading with school children and men's and woman's groups. Outings organised include shopping trips, visits to the lake and the beach, city tours and visits to other facilities. There are designated drivers and the DTs have current first aid certificates. A resident advocate attends regular resident meetings. Lifestyle forms are completed in consultation with the resident and family on admission of a new resident. The DT completes a resident assessment within three weeks of admission and develops the activity plan within six weeks of admission. The clinical care plan and activity plan are reviewed at the same time.</p>	<p>The DT team leader is an Eden associate/driver for the Eden philosophy. The organisation has achieved accreditation of seven Eden principles. There is a set activity programme across the facility that is resident focused and is planned around meaningful everyday activities such as gardening, baking, reminiscing, feeding birds, assisting the hairdresser, dusting, tidying drawers and making own beds (if able). A retired guide dog visits Monday to Friday. The programme is supported by 14 volunteers. There is evidence that the residents have regular input into review of the programme (via Eden circles and resident surveys) and this feedback is considered in the development of the residents activity programme. Residents interviewed expressed a high level of satisfaction with the programme and confirmed that they felt listened to and had input into the development of their activity programme. Relatives interviewed advised that the activity programme was interesting with lots of choice and the residents were really encouraged to participate.</p> <p>The hospital programme is flexible according to the resident abilities and preferences. There is the ability to run activities simultaneously in both areas. There is a large lounge area in both units and a recreational room suitable for one on one or small group activities. A number of activities (jigsaws, craft, photo albums,</p>

			<p>books, music tapes bowls) were observed placed around the facility for the residents to access. Care staff were observed engaging residents in completing jigsaws and looking at the photo albums.</p> <p>Church services and other religious services for Easter, ANZAC and Christmas are held. Entertainment is provided on a regular basis and includes musical groups, speakers, SPCA and pet visits. Guest speakers are invited to the seminars. Residents are encouraged to maintain their community links with churches and external organisations such as the RSA.</p> <p>The LTCP includes Eden headings for memory, (behaviour and mood), loneliness (companions), helplessness (socialisation). There is a key link between the LTCP, and the activities programme which is regularly reviewed and evaluated for effectiveness.</p>
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End of the report.