

# Presbyterian Support Central - Kandahar

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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>	Kandahar Court  Kandahar Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 20 October 2016      End date: 21 October 2016
<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>	56

# 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
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

Kandahar Home and Kandahar Court are part of the Presbyterian Support Central (PSC) organisation. The service provides rest home, hospital and dementia levels of care for up to 88 residents between Kandahar Home (63 rest home and hospital beds) and Kandahar Court (25 dementia care beds). On the day of the audit there were 56 residents.

The service is overseen by an interim facility manager, who is a registered nurse and well qualified and experienced for the role. A facility manager has been recruited and appointed. The facility manager and clinical nurse manager are supported by the registered nurses and the regional operations manager. Residents and family interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management.

The service has achieved a continual improvement related to food services.

This audit has identified the following areas requiring improvement: incident reporting, ensuring scheduled meetings are held, completion of advance directives and restraint monitoring.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The service complies with the Code of Health and Disability Consumers' Rights. Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Staff and residents interviewed were familiar with the complaints management process.

## 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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PSC Kandahar continues to implement the Presbyterian Support Services Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to monthly senior team meetings. An annual resident satisfaction survey is completed and there are regular resident and family meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented induction programme for all roles within the service. 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.

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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.

Kandahar Home and Kandahar Court have a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by an authorised technician. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the Kandahar Home and Kandahar Court including lounge and dining areas and small

seating areas. There is a designated laundry and cleaner's rooms. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade provided. There is a secure outdoor walking path and garden area for the dementia area at Kandahar Court.

## 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 low risk.</p>
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There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There is currently one hospital level resident requiring restraint and no residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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	1	45	0	4	0	0	0
Criteria	1	95	0	5	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)
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 Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) has been incorporated into care. Discussions with eight healthcare assistants (three rest home, three hospital and two dementia level) identified their familiarity with the Code of Rights. Interviews with ten residents (seven rest home and three hospital) and nine family members (five rest home, two hospital and two dementia level) confirmed that the service functions in a way that complies with the Code of Rights. Observation during the audit confirmed this in practice.</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>	PA Low	<p>The service has in place a policy for informed consent and resuscitation and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are signed general consents, including outings, on nine of nine resident files sampled (three hospital – one of which was respite, four rest home and two dementia level care residents). Resuscitation treatment plans were appropriately signed in the hospital and rest home files reviewed but not for the dementia files.</p> <p>Discussion with residents and relatives confirmed that the service actively involves them in decisions that affect their/their relative's lives.</p> <p>Informed consent processes are also reviewed through the six-monthly multidisciplinary review with residents and relatives and links to the quality system through annual satisfaction surveys.</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>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. The information pack provided to residents at the time of entry to the service also provides residents and family/whānau with advocacy information. Interviews with healthcare assistants, residents and relatives informed they were aware of advocacy and how to access an advocate.</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>Interviews 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. Discussion with staff, relatives and 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>	FA	<p>There is a complaints policy to guide practice and this is communicated to residents and family members. The facility manager leads the investigation and management of complaints (verbal and written). A complaint's register records activity. Complaint forms are visible around the facility. Two complaints have been made since the last audit in February 2016. One complaint was lodged with the Health &amp; Disability Commissioner; a letter has been received recently stating that there would be no further action taken. The two complaints reviewed were appropriately investigated and resolved to the satisfaction of the complainant, any corrective actions identified were implemented. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A copy of the 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>	FA	<p>Code of Rights leaflets were available in the front entrance of the facility. Code of Rights posters were on the walls in the hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets were available at the front entrance foyer. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families at interview confirmed they were informed of the scope of services and any liability for payment for items not included in the scope.</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>	FA	<p>There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people's beliefs and values. A tour of both facilities 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. Residents and families interviewed confirmed that staff were respectful, caring and maintain their dignity, independence and privacy at all times. 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.</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>	FA	<p>There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. The service's philosophy results in each person's cultural needs being considered individually. On the day of the audit, there were two residents that identified as Māori within the service.</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>	FA	<p>The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the facility manager or clinical nurse manager, along with the resident and family/whānau complete the documentation. Residents and family interviewed confirmed that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other</p>	FA	<p>Discrimination, coercion, exploitation and harassment policies and procedures are in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination free environment. The Code of Rights is included in orientation and in-service training. Interviews with staff confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identify that privacy is ensured.</p>

exploitation.		
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care and dementia needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and dementia level care. Staff stated that they feel supported by the management team. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.</p>
<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. Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Forms reviewed for October 2016 identified family were notified following a resident incident. Interviews with healthcare assistants inform family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. Discussions with residents and family members confirmed they were given time and explanation about services on admission. Resident meetings occur at Kandahar Home and family meetings at both Kandahar Home and Court. (Resident meetings occur every three months and relative meetings are six-monthly).</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>	FA	<p>Kandahar Homes are part of the Presbyterian Support Central (PSC) organisation. The service provides rest home, hospital and dementia care levels of care for up to 88 residents between Kandahar Home (33 rest home beds and 30 hospital beds) and Kandahar Court (25 dementia care beds). On the day of the audit there were 56 residents. There were 22 rest home level residents, 16 hospital level residents, including two residents on respite and 18 residents in the dementia unit, including one resident on respite. There were no resident's under the medical component of the certificate. All residents were on the ARC contract.</p> <p>At the time of the audit, there was an interim facility manager at PSC Kandahar who commenced in September 2016. Advised by the regional manager, that a new facility manager had been appointed and will commence from 15 November 2016. There is a clinical nurse manager and clinical coordinator (Kandahar Court) who provide support to the facility manager. The clinical nurse manager has been in the position since August 2016 and has over 17 years' experience within the aged care industry. The clinical coordinator has worked at the service for over twenty years and three years in the dementia unit. There is also a quality coordinator/educator, who is a registered nurse (RN) and has been in the role for five years with experience in aged care. The facility manager is supported by a regional manager (non-clinical) who</p>

		<p>visits the site weekly and was present during the audit.</p> <p>Kandahar has a 2016-2017 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, the Eden alternative and health and safety. Progress towards goals (and objectives) is reported through the manager reports taken to the monthly senior management team meeting. The goals for 2015-2016 business plan have been reviewed.</p>
<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>	FA	<p>The clinical nurse manager undertakes the role in the temporary absence (e.g. annual leave) of the facility manager and would be supported by the regional manager and the Presbyterian Support Central (PSC) office.</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>	PA Low	<p>Presbyterian Support Central has an overall Quality Monitoring Programme (QMP) and PSC Kandahar participates in the PSC benchmarking programme. The service has a quality coordinator. The senior team meeting acts as the quality committee and they meet twice a month. Information is fed back to the monthly clinical focused meetings and staff meetings. There is an annual meeting schedule including staff (full facility) meetings. Staff meetings are scheduled to be held monthly but these have not always occurred. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms, which are being signed off and reviewed for effectiveness. The facility manager had an understanding of the contractual agreements and requirements. The regional manager has provided oversight and support to the facility manager on a weekly basis.</p> <p>Progress with the quality programme/goals has been monitored and reviewed through the monthly senior team meetings. There is an internal audit calendar in place and the schedule has been adhered to for 2015 and 2016 (year to date). Data is collected in relation to a variety of quality activities, including accidents/incidents, falls and infection control. There has been no discussion around quality data trend analysis at staff meetings since the last audit. 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 and safety meetings include identification of hazards and accident/incident reporting and trends.</p> <p>The service has policies and procedures to provide assurance that it is meeting accepted good practice and</p>

		<p>adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. An organisation policy review group has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office. The quality coordinator is responsible for document control within the service; ensuring staff are kept up to date with the changes. An organisational staff training programme is being implemented and based around policies and procedures. A resident satisfaction survey is completed annually. The 2015 survey informed an overall satisfaction with the service for residents at 87.0% and an overall satisfaction with the service for relatives at 84.1%. The 2016 resident/relative survey is to be sent out on 25 October 2016.</p>
<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>	PA Low	<p>The service collects a set of data relating to adverse, unplanned and untoward events. However, incident reports were not evidenced to be completed for all adverse events. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services (link 1.2.3.6). Nine incident forms for Kandahar Home (hospital/rest home) and seven incident forms for Kandahar Court (dementia care unit) for October 2016 were sampled. All incident forms have been fully completed and residents reviewed by a registered nurse. There is documented evidence of relative notification on all 16 accident/incident forms. Discussions with the regional manager and interim facility manager, 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>	FA	<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. A copy of qualifications and annual practising certificates including registered nurses, general practitioners and other registered health professionals are kept. Nine staff files were reviewed (one clinical nurse manager, one clinical coordinator, two registered nurses, two healthcare assistants, one cook, one recreational officer and one enrolled nurse/health and safety officer). All staff files reviewed included the appropriate employment and recruitment documents including annual performance appraisals.</p> <p>The service has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. The clinical nurse manager recently completed an orientation programme. A training programme is being implemented that includes eight hours of annual education. The registered nurses and care staff attend PSC professional study days, which cover the mandatory education requirements and other clinical requirements. Attendance is monitored. The staff training plan includes regular sessions occurring as per the monthly calendar. Twenty-three of twenty-three healthcare assistants who are employed in the dementia care unit have completed their dementia specific units.</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>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. The facility manager, clinical nurse manager and clinical coordinator work full-time. Registered nurses cover each 24-hour period in the hospital/rest home area. Agency staff are used to provide cover for sickness if necessary. The HCA numbers per area are adequate. Interviews with HCA's, residents and family members identify that staffing is adequate to meet the needs of residents. Staff levels and skill mix are meeting contract and industry norm requirements. Staffing levels are benchmarked against other PSC facilities.</p> <p>There was sufficient staff rostered in the dementia unit, there is an RN rostered on 7 days a week, 8.00am to 4.30pm Monday to Friday and in the weekends 7.00am to 3.30pm. There are at least four HCA's on the AM, PM shifts and two on the night shift.</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' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.</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>The service has comprehensive admission policies and processes in place. Residents and or relatives receive an information pack outlining services able to be provided, the admission process and entry to the service and also contains all relevant information for dementia level care. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager and clinical nurse manager. The admission agreement form in use aligns with the requirements of the ARC contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated</p>	<p>FA</p>	<p>The service has transfer and discharge procedures in place. Transfers are planned and coordinated in consultation with the family/whānau as appropriate. All relevant information is documented and communicated to the receiving health provider or service.</p>

transition, exit, discharge, or transfer from services.		
<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>	FA	<p>The medication management policies and procedures comply with medication legislation and guidelines. The service has four-weekly medico blister packs. Blister pack medications are checked on arrival at each site by a registered nurse. There is a signed agreement with the providing pharmacy. Four medication storage areas were audited. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Weekly stocktakes of controlled medication are undertaken by the registered nurses. Fridge temperatures are routinely checked (records sighted).</p> <p>Registered Nurses, enrolled nurses and healthcare assistants (HCAs) who have attained competency in medication administration, administer medications. Some HCAs have competency for checking of medications only. Eighteen individual resident's medication charts were sighted. There were no standing orders. Individual residents have a range of 'PRN' medications prescribed, should they be required, with indications for use. The general practitioners review medications three-monthly and as required.</p> <p>The self-medicating policy includes procedures on the safe administration of medicines. There is currently one rest home resident who self-medicates an inhaler. Self-medicating competency is included in the three-monthly medication review.</p> <p>The service undertakes a medication audit six-monthly. The pharmacy undertakes a full count of controlled medications when delivered and have completed six-monthly audits of controlled medications.</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>	CI	<p>All meals are prepared and cooked on-site in the main kitchen in Kandahar Home. Meals are transported in a van to Kandahar Court kitchen in insulated hot boxes. There is a four-weekly rotating menu which had been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen adjacent to the rest home dining room and served directly to rest home residents. Hospital and dementia unit residents have their own dining rooms with an adjacent kitchen servery. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. Staff were observed assisting residents with their lunchtime meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the registered nurses. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a GP/dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. There are snacks available in the dementia unit at all times.</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>When entry to the service is declined, the resident is referred to the referrer to ensure that the resident is admitted to the appropriate level of care provider.</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>The registered nurses complete an initial assessment on admission including risk assessment tools. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. InterRAI assessments had been completed in all permanent resident files reviewed. Care plans sampled were developed on the basis of these assessments. The recreation staff complete an activity assessment that identifies individual activities and preferences and transfers this information into each resident's recreation plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Resident care plans reviewed were resident-focused. All identified support needs were included in the care plans for nine of nine files sampled. Care plans sampled, evidenced resident (as appropriate)/family/whanau involvement in the care plan process. Relatives interviewed confirmed they are involved in the care plan process. Resident files demonstrate service integration. Care plans included appropriate interventions, strategies for managing challenging behaviours and monitoring behaviour charts were in use when appropriate.</p> <p>Short-term plans are used for short term needs. Short-term care plans sited in resident files were for wounds, prevention of pressure injury, falls risk, pain, challenging behaviour, infection, weight gain and weight loss.</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>	FA	<p>When a resident's condition alters, a registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to): accidents/incidents, infections, health professional visits and changes in medications.</p> <p>There is specialist input from the DHB liaison nurse in the dementia unit. Strategies for the provision of a low stimulus environment could be described by the care team.</p>

		<p>Adequate dressing supplies were sighted in treatment rooms and cupboards. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds, skin tears and pressure injuries. There is evidence of nurse practitioner and DHB wound care nurse specialist involvement in the treatment of chronic wounds/pressure injuries.</p> <p>Residents are weighed monthly. Nutritional requirements and assessments are completed on admission identifying resident nutritional status.</p> <p>Continence products are available and resident files include urinary continence assessment, bowel management and continence products identified for use.</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>FA</p>	<p>There are four staff in the recreation team. A recreation officer is rostered to work in Kandahar Court (dementia unit) 12.30 -18.00hrs over seven days a week (the recreation officer is enrolled in DT training with Careerforce and has completed ACE dementia units).</p> <p>The team leader recreation officer works 40 hours per week in Kandahar Home Monday- Friday. Resources are available at both sites for care staff to access when recreation staff are not at work. There are recreational programmes running that are meaningful and reflect ordinary patterns of life. During the 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 weekly and volunteers provide regular support to the programme.</p> <p>There is evidence that the residents have input into review of the programme via the resident survey and this feedback is considered in the development of the resident's activity programme. The activity programme is developed a week in advance Residents and families interviewed report satisfaction with the activities programme. The Eden philosophy is implemented and residents' skills and abilities are celebrated and valued within the programme. One rest home resident interviewed has a keen interest in craft, jewellery making, sculpting and other art projects. The service has provided a designated "work room" where the resident can be creative and display all arts and crafts projects. The residents interviewed enjoy planting and harvesting the vegetable garden, looking after the chickens, singing in choir, quizzes, team games, crafts, outings and entertainment.</p> <p>An activity profile is completed on admission in consultation with the resident/family (as appropriate). The activities documentation in the resident files sampled reflects the specific requirements of each resident and includes activities which could be used to distract behaviours. The recreational plans had been reviewed six-monthly. Activity participation was noted in the progress notes.</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>All initial care plans sampled were evaluated by a registered nurse within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. Reassessments have been completed using interRAI LTCF for all residents who have had a significant change in health status. In resident files sampled, short-term care plans were evidenced evaluated and resolved or added to the long-term care plan if the problem is ongoing. The multidisciplinary team (MDT) includes the GP, the nurse practitioner and pharmacist. The GP reviews medications three-monthly and the NP undertakes a detailed three-monthly review of the resident. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes.</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 the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to the psycho-geriatrician, geriatrician, physiotherapist, eye specialist, occupational therapist, podiatrist and hospital nurse specialists including the lymph-oedema nurse, respiratory nurse, diabetes nurse, dementia nurse and palliative nurse.</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>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>Both sites have a current building warrant of fitness, which expire 01-07-2017. Health and safety meetings have been held quarterly. Minutes of health and safety meetings reviewed evidenced discussion of revisions made to accident, incident and near miss policy to align with new Health and Safety Act. Hot water</p>

<p>an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>temperatures are checked monthly. Medical equipment and electrical appliances have been tested, tagged and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. Healthcare assistants interviewed confirmed there was adequate equipment to carry out the care according to the resident needs as identified in the care plans.</p> <p>Residents in Kandahar Court have access to safely designed external areas that have shade.</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 were sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities were available. Residents interviewed state their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets and showers were well signed and identifiable and include vacant/in-use signs.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>The resident rooms were spacious enough to meet the assessed resident needs. Residents were able to manoeuvre mobility aids around the bed and personal space. All beds were of an appropriate height for the residents. Healthcare assistants interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms were personalised.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible</p>	<p>FA</p>	<p>There are large lounges and small seating areas in the Kandahar Home and Kandahar Court. The dining rooms were spacious and located directly off the kitchen/servery area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed report they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges in the dementia unit (Kandahar Court). In Kandahar Home, there is a large recreation room.</p>

areas to meet their relaxation, activity, and dining needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</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 linen and personal clothing is laundered by designated laundry staff at Kandahar Home. There are secure cleaners' cupboards with cleaners trolleys. Staff have attended infection control and safe chemical handling education and there was appropriate protective clothing available. Manufacturer's data safety charts are available. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of resident rooms and communal areas.</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>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. The facility is well prepared for civil emergencies and has civil defence kits (readily accessible) that are checked monthly. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, torches, batteries and radio.</p> <p>The backup generators are run for half an hour monthly. Emergency lighting is checked. There is a barbeque and gas bottles for alternative cooking source. The staff interviewed were able to describe the emergency management plan and how to implement this. Fire training and security situations are part of orientation of new staff. A minimum of one person trained in first aid is available at all times. There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</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>	FA	<p>All resident rooms have an external window providing natural light. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable.</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. In June 2016, PSC introduced a new software programme to assist with benchmarking of data. Summaries of these results are reported back through the senior management meeting however; trend analysis was not evidenced as discussed at staff meetings (link to 1.2.3.6). 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 (registered nurse) provides feedback at staff meetings. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation.</p> <p>The governing body are responsible for the development of the infection control programme and its review.</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 is discussed at monthly senior management/team leader meetings and staff meetings. The staff meetings are attended by a cross section of staff from all areas of the service including: management, clinical, kitchen, cleaning, laundry and maintenance. The service also has access to the PSC clinical director and nurse consultant, the DHB infection control nurse specialist, public health and the 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</p>	<p>FA</p>	<p>There are PSC infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated</p>

type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator (registered nurse) has completed a level 7 qualification in infection control. The IC coordinator has maintained skills and knowledge of infection control practice through attendance at the annual PSC infection control nurse peer support day. The infection control coordinator also has access to the microbiologist, pharmacist, DHB infection control nurse, Public Health, Med Lab, GP's, expertise within the organisation and external infection control specialists.</p> <p>The infection control coordinator provides infection control orientation to all new staff. Infection control education is part of the professional nurses and healthcare assistants study days that are held annually. 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>	FA	<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 at PSC Kandahar. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP and lab staff 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 management/team leader and staff meetings, however, trend analysis was not evidenced as discussed at staff meetings (link to 1.2.3.6). The senior management/team leader meetings include the monthly infection control report. Individual resident infection control summaries are maintained. All infections are documented on the infection monthly online register. The surveillance of infection data assists in evaluating compliance with infection control practices. Short-term care plans were evidenced as completed for infections. There have been no outbreaks reported since previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has restraint minimisation and safe practice policy in place. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. Enablers are voluntary. There was one hospital resident with a restraint and no residents requiring the use of an enabler.</p> <p>Staff are trained in restraint minimisation, challenging behaviour and de-escalation and competencies are completed.</p>
Standard 2.2.1: Restraint	FA	The clinical manager is the restraint coordinator. Assessment and approval process for restraint use

approval and processes 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.		includes the restraint coordinator, registered nurses, resident/or representative and medical practitioner.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whānau in the file sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Low	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified through the assessment and MDT approval processes. The hospital resident's file reviewed had a completed comprehensive assessment form and a care plan that reflected risk. Monitoring forms reviewed did not consistently evidence that monitoring was occurring in the prescribed timeframes. The service has a restraint and enablers register which was up to date.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every six months. In the restraint file reviewed, six-monthly evaluation had not occurred as the resident had recently been assessed for the use of restraint. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at senior management/team leader meetings and at staff meetings. Evaluation timeframes are determined by policy and risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review	FA	Organisational review of restraint use was evidenced to be conducted annually by the PSC resident safety group. A review of all enabler and restraint use occurs monthly at the senior management/team leader meetings and audits are completed as part of the quality monitoring programme.

Services demonstrate the monitoring and quality review of their use of restraint.		
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## 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 1.1.10.7</p> <p>Advance directives that are made available to service providers are acted on where valid.</p>	PA Low	<p>In the rest home and hospital, resuscitation plans were correctly signed in seven of seven files viewed. Two files also contained advance care plans which were correctly signed by the resident. Two advance care plans of dementia residents were evidenced to be signed by EPOAs.</p>	<p>Two advance care plans of dementia residents were evidenced to be signed by EPOAs. RNs interviewed lacked knowledge around informed consent and completion of advanced care plans.</p>	<p>Ensure advance care plan/directives are signed by the resident assessed as competent to make an informed decision. Ensure RNs are trained around advanced directives/informed consent.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and</p>	PA Low	<p>Data is collected in relation to a variety of</p>	<p>There was no evidence of</p>	<p>Ensure that accidents/incidents,</p>

the results communicated to service providers and, where appropriate, consumers.		quality activities, including accidents/incidents, falls and infection control. There has been no discussion around quality data trend analysis at staff meetings since the last audit in February 2016.	documented discussion around accidents/incidents, falls and infection trend analysis at staff meetings since the last audit in February 2016.	falls and infection trend analysis is discussed in staff meetings.  90 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	There is an annual meeting schedule including staff (full facility) meetings. Staff meetings are scheduled to be held monthly but these have not always occurred.	There is no evidence of staff meetings being held in April, May and July 2016.	Ensure that all scheduled staff meetings are held.  90 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Low	The service collects a set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. Pressure injuries were not all included on an incident form.	There was no evidence of a completed incident form for a pressure injury that was identified on 21 July 2016.	Ensure that incident forms are completed for all pressure injuries that occur.  90 days
Criterion 2.2.3.4	PA Low	Monitoring forms were evidenced completed	Monitoring of restraint when in	Ensure monitoring of the resident

<p>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:</p> <ul style="list-style-type: none"> <li>(a) Details of the reasons for initiating the restraint, including the desired outcome;</li> <li>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</li> <li>(c) Details of any advocacy/support offered, provided or facilitated;</li> <li>(d) The outcome of the restraint;</li> <li>(e) Any injury to any person as a result of the use of restraint;</li> <li>(f) Observations and monitoring of the consumer during the restraint;</li> <li>(g) Comments resulting from the evaluation of the restraint.</li> </ul>		<p>for one resident requiring the use of a restraint. However, monitoring of the restraint when in use was not evidenced to be completed within the prescribed timeframe.</p>	<p>use was evidenced to be documented as occurring two hourly and not hourly as prescribed in care plan.</p>	<p>during the use of restraint is completed in the timeframe prescribed to minimise the risks around the use of restraint.</p> <p>90 days</p>
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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 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the</p>	CI	<p>The kitchen is able to meet the nutritional needs of residents in the rest home, hospital and dementia units. The kitchen staff have completed food safety training. The cooks follow a four-weekly seasonal menu, which is reviewed by a dietitian and adapted to reflect resident preference. The service has exceeded the service standards for meal services.</p>	<p>In response to results from resident and relative satisfaction surveys around improvements required to the meal services in October 2015, the service reviewed the menu, meals, dining room décor and the kitchen and meal services. A plan was put in place to improve services.</p> <p>The plan included training for staff and a change to meal services. The service now offers a continental breakfast which is available from 6am in the dining room in both Kandahar Home and Kandahar Court for any residents who wish to eat early and are able to serve themselves. There is a designated “director of meal service” appointed at each meal time. This person ensures that the kitchen hands serve the correct portion size and cater for individual resident’s likes and dislikes. A review of the menu was completed and suggestions from residents were acted upon and meals reflect resident preferences. The menu has enticing names for the meals to encourage resident appetite. The puree meals have also been reviewed and are now presented in a very attractive manner. This accompanied with additional initiatives such as the Kandahar Café, cards with “Grace” prayer written in English and te reo Māori have been provided, larger noticeboards with the menu clearly displayed in each area have been provided, table decorations and place mats made by residents and repainting the dining areas has</p>

consumer group.			<p>resulted in increased resident satisfaction.</p> <p>To effectively evaluate progress, the service conducted weekly “smiley face” surveys from October 2015- February 2016 with a focus group of ten residents. Results were analysed at weekly meetings and progress was graphed. A review of data evidences that of the eighteen objectives around the meal service, all have evidenced a substantial increase in resident satisfaction. The facility presented their project and results at PSC Care Metric study day.</p>
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End of the report.