

# Presbyterian Support Central - Kilmarnock Heights

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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:

**Legal entity:** Presbyterian Support Central

**Premises audited:** Kilmarnock Heights

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 17 November 2016 End date: 18 November 2016

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 29

# 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

PSC Kilmarnock Heights is owned by Presbyterian Support Central and provides rest home level care for up to 40 residents. On the day of the audit there were 29 rest home residents.

The service is overseen by a facility manager (non-clinical) who is experienced for the role. The facility manager is supported by a clinical nurse manager and the regional manager (non-clinical). 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.

This audit has identified improvement required around timeframes.

The service is commended for achieving a continued improvement rating around 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.		Standards applicable to this service fully attained.
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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.		Standards applicable to this service fully attained.
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PSC Kilmarnock Heights 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 meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented orientation 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.		Some standards applicable to this service partially attained and of low risk.
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The facility manager takes primary responsibility for managing entry to the service with assistance from the clinical nurse manager. Comprehensive service information is available. Initial assessments are completed by a registered nurse. Care plans are based on the interRAI outcomes and other assessments. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed. All meals and baking is prepared and cooked on-site. Resident's individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus. Staff are trained in food safety and hygiene. Residents interviewed were complimentary about the food service.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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PSC Kilmarnock Heights rest home is located on an elevated section with rural views. The building has a current building warrant of fitness and fire service evacuation approval. All rooms are single, personalised and have a hand basin. There is adequate room for residents to move freely about their bedrooms and communal areas using mobility aids. Each "neighbourhood" has a kitchenette area for residents to make a cup of tea. The communal dining and lounge seating placement encourages social

interaction within the rest home. Outdoor areas and the internal courtyard 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 maintain 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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There is a restraint policy in place that states the organisations philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit, there were no residents with restraint or enablers at PSC Kilmarnock Heights. There is a restraint coordinator for the service, who is the clinical nurse manager. Restraint minimisation, enabler use and challenging behaviour training is 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.
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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)
<b>Standards</b>	1	43	0	1	0	0	0
<b>Criteria</b>	1	91	0	1	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>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) has been incorporated into care. Interviews with four healthcare assistants who work across each am, pm and night shifts and two registered nurses confirmed their understanding of the Code. Interviews with six residents and five family members confirmed that the service functions in a way that complies with the Code of Rights. Observation during the audit confirmed this in practice. Staff receive training about resident rights at orientation and as part of the in-service training programme.</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>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Six resident files sampled demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All resident files sampled had a signed admission agreement signed on or before the day of admission and consents.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>A policy describes access to advocacy services. 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 family members informed they were aware of advocacy and how to access an advocate.</p> <p>Residents are part of decision making and in 2015 were instrumental in the writing of the PSC Residents Standard of Conduct and Residents Rights which is now part of the admission agreement for all of PSC.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>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. Discussion with staff, residents and family members confirm residents are supported and encouraged to remain involved in the community and external groups.</p> <p>The service has successfully gained all 10 principles of the Eden Alternative Philosophy in August. They have created a human habitat to eliminate loneliness, helplessness and boredom through providing close and continuous contact with animals, plants and children. They created three habitat groups – animals, plants and people (children, family, volunteers). Links with the community are well-maintained.</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>The service has a complaints policy in place and residents and their family/whānau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whānau. A complaint register and folder is maintained with all documentation. There have been seven complaints made since the last audit. Response to complaints is recorded and includes meetings with complainants, the recording of resolution and outcomes. The facility manager is responsible for complaints management and advised that both verbal and written complaints are actively managed.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	<p>FA</p>	<p>Code of Rights leaflets are available in the front entrance of the facility. Code of Rights posters are on the walls in the hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance foyer. Information is also given to next of kin</p>

rights.		or enduring power of attorney (EPOA) to read to and discuss with the resident in private. A manager discusses the information pack with residents/relatives on admission. Residents and relatives interviewed confirmed that information had been provided to them around the Code. There is the opportunity to discuss aspects of the Code during the admission process. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	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. 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 are 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.
Standard 1.1.4: Recognition Of Māori Values And Beliefs  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.	FA	There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The service has access to a cultural advisor from Poneke Ki, Te Whanganui a Tara (Māori Anglican Vestry). Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. Cultural needs are addressed in the care plan. On the day of the audit there was one resident that identified as Māori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	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.
Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion,	FA	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

harassment, sexual, financial, or other exploitation.		confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identify that privacy is ensured.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care 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 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>Enliven training is now guided by a training advisory group made up of the general manager, clinical director, selected managers and clinical nurse managers. The home manager maintains the overview and coordination of training attendance and record-keeping at home level.</p> <p>The Enliven Excel based registers were transferred to a database environment in 2014 which enables the service to sort all entries e.g. incidents, infections, falls by resident. This is utilised proactively in practice to identify “residents of concern” and inform support and communication plans for those residents.</p> <p>The service has successfully gained all 10 principles of the Eden Alternative Philosophy in August. They have created a human habitat to eliminate loneliness, helplessness and boredom through providing close and continuous contact with animals, plants and children.</p> <p>A falls prevention programme is in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Part of the falls prevention programme included identifying residents at risk of falling, providing falls prevention training for staff, reviewing call bell response times, reviewing the roster to ensure adequate supervision of residents, encouraging resident participation in the activities programme and increased staff awareness of residents who are at risk of falling.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	There is an open disclosure policy. Residents and family members 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. Incident forms reviewed for November 2016 identified family were notified following a resident incident. Relatives interviewed confirmed they are notified of any changes in their family member’s health status. Interviews with healthcare assistants confirm that family are kept informed. Resident meetings occur every two

communication.		months.
<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>PSC Kilmarnock Heights Rest Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home level of care for up to 40 residents. On the day of the audit there were 29 rest home residents including one respite resident on a non-aged residential contract. All other residents were on the ARCC agreement.</p> <p>The facility manager has a certificate in management studies and has been at PSC Kilmarnock Heights for 11 years. She has been in the facility manager role for six and a half years. The facility manager is supported by a clinical nurse manager. The clinical nurse manager has been in the position since August 2015 and has over six years' experience within the aged care industry. The service is also supported by a regional manager.</p> <p>PSC Kilmarnock Heights has a 2016-2017 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. The goals for 2015-2016 business plan have been reviewed by the facility manager and regional manager. Progress towards goals (and objectives) is reported through the facility manager reports taken to the monthly senior management team meeting and discussed at staff meetings. PSC Kilmarnock Heights recently became an Eden Alternative home in August 2016 and has achieved 10 principles of Eden Alternative.</p> <p>Residents and staff wrote the Kilmarnock values statement.</p> <p>The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home.</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 of the facility manager and is supported by the regional manager and the Presbyterian Support Central (PSC) head 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>	<p>FA</p>	<p>Presbyterian Support Central has an overall Quality Monitoring Programme (QMP) that is part of the quality programme and includes internal benchmarking with the other PSC sites. 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. A range of other meetings is 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. The facility manager had an understanding of the contractual agreements and requirements. The regional manager provides oversight and support to the facility manager on a fortnightly 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). Feedback on monthly accident and incidents are provided to all meetings. The service has linked the complaints process with its quality management system, including the benchmarking programme and fed back through the quality and staff meetings. The service has a health and safety management system and this includes a health and safety rep who has completed health and safety level three training. Monthly reports are completed and reported to meetings and at the four-monthly health and safety committee meeting. Health and safety committee 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 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 facility manager is responsible for document control within the service; ensuring staff are kept up to date with the changes. A resident and relative satisfaction survey is completed annually. The 2016 surveys informed an overall satisfaction with the service for residents at 88.2% and an overall satisfaction with the service for relatives at 100%.</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</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. 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 can be used for comparative purposes with other similar services. Senior team meetings and clinical focused meeting minutes include analysis of incident and accident data and corrective actions.</p> <p>A review of 12 incident forms (six falls, three skin tears, two bruises and one pressure injury) identified that forms are fully completed. Follow-up assessments by a registered nurse include neurological</p>

<p>of choice in an open manner.</p>		<p>observations for those residents that had an unwitnessed fall or hit their head. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Three section 31 incident notification forms were completed in 2016 (all sighted) in relation to two matters referred to the police and one in relation to health and safety (land slip). The appropriate action has been taken in relation to the matters outlined in the mandatory notifications that were sighted.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>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 and general practitioners and other registered health professionals are kept. Six staff files were reviewed (one clinical nurse manager, one registered nurse, two healthcare assistants, one cook and one recreational 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 completed an orientation programme that included two comprehensive orientation books that included checklists for completion. A training programme is being implemented that includes eight hours of annual education. The healthcare assistants attend PSC training days, which cover the mandatory education requirements. Attendance is monitored. The staff training plan includes regular sessions occurring as per the monthly calendar.</p> <p>Enliven training is guided by a training advisory group made up of the general manager, clinical director, selected managers and clinical nurse managers. The home manager maintains the overview and coordination of training attendance and record-keeping at home level.</p> <p>Since 2014 a third clinical and a third professional study days have been added to allow additional focus on clinical issues, e.g. recognising frailty and time for quality improvement systems and processes are discussed.</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</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 and clinical nurse manager work full-time, Monday through Friday. There is a part time registered nurse that works 32 hours per week including Saturday and Sunday. Care staff have access to an RN who is oncall. The oncall is shared by the Clinical Nurse Manager and RN. Advised that extra staff can be called on for increased resident requirements. Interviews with four healthcare assistants, six residents and five family members identify that staffing is</p>

providers.		adequate to meet the needs of residents.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. 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>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager in consultation with the clinical nurse manager screens all potential residents prior to entry and records all admission enquires in a hard copy system. 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 ARRC contract.
<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>	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential (yellow) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur.
<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	Twelve medication charts were sampled. The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication room/cupboard. Medication administration practice complies with the medication management policy for the medication round sighted. Medication prescribed is signed as administered on the pharmacy generated signing chart. Registered nurses administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners write medication charts correctly and there was

		evidence of three-monthly reviews by the GP. Six residents are self-administering their own medicines and the documentation was correctly recorded and competency assessments were completed.
<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>	FA	<p>There is a fully functional kitchen and all food is cooked on-site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. The kitchen can meet the needs of residents who require special diets and the cooks work closely with the RNs on duty. The kitchen staff have completed food safety training.</p> <p>The kitchen follows a rotating seasonal menu, which has been reviewed by an external dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.</p> <p>The service has made a number of changes to the food service following feedback from residents including (but not limited to): (i) increased the fresh food options for light meals (i.e. reducing use of processed foods); (ii) Diversified the meals to include meals that would appeal to a broader ethnic range, and (iii) The Kilmarnock cook attended the annual peer support, at which Peter Morgan-Jones from Hammond Care Australia demonstrated the use of pureed food molds and finger food to enable independence as well as ensuring nutritional value for dementia care residents.</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 records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred to the referring agency for appropriate placement and advice. Information on alternate placement options is given out.</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>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed when there was a change to a resident's health condition. Two of three registered nurses (one clinical nurse manager and one registered nurse) are interRAI trained. InterRAI assessments have been completed for all residents (link</p>

		1.3.3.3). Care plans sampled were developed based on these assessments.
<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>The long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. The interRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans were in use for changes in health status. Staff interviewed reported they found the plans easy to follow.</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>Registered nurses (RNs) and health care assistants, follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the district nurse [hospice nurse]). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring and wound management plans are in place for residents. On the day of audit, there were eight wounds including one resident with a grade II facility acquired pressure injury (link tracer 1.3.3). All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Interviews with registered nurses and healthcare assistants demonstrated an understanding of the individualised needs of residents. Care plan interventions demonstrate interventions to meet residents' needs. There was evidence of pressure injury prevention interventions such as two-hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of</p>	CI	<p>The service has achieved the 10 Eden principles, demonstrating a commitment to maximising resident independence and making service improvements that reflect the wishes of residents. PSC Kilmarnock Heights recreational programme (design, implementation and review) follows the Eden philosophy and is resident-focused and individualised to reflect the resident wishes. The programme meets the recreational needs of the residents and reflects normal patterns of life. The programme is supported by a team of 25 volunteers.</p> <p>The service employs two recreational officers who work a combined total of 60 hours per week. A</p>

<p>the service.</p>		<p>volunteer (a retired Diversional Therapist) provides a programme on a Sunday. The recreational programme is resident-focused and is planned around meaningful everyday activities such as gardening, baking, reminiscing, feeding birds, dusting, tidying drawers and making own beds (if able).</p> <p>There is evidence that the residents have regular input into review of the wider programme (via Eden circles and resident surveys) and this feedback is considered in the development of the resident's activity programme. Residents interviewed expressed a high level of satisfaction with the program and confirmed that they felt listened to and had input into the development of their individual activity plan and the 'what happens' in their home.</p> <p>An activity profile is completed on admission in consultation with the resident/family (as appropriate). The documentation in the resident files sampled was full and reflected the interests, hobbies and uniqueness of each resident. Relatives interviewed advised that the activity program was interesting with lots of choice and the residents were encouraged to participate. Residents and families interviewed evidenced that the activity programme had a strong focus on maintaining independence and reducing boredom.</p> <p>In the files reviewed the recreational plans had been reviewed six-monthly at the same time as the care plans were reviewed. Activity participation was noted in the progress notes.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that not all long-term care plans were evaluated at least six-monthly, however there was evidence that the care plans are evaluated if there is a change in health status (Link 1.3.3.3). There was at least a three-monthly review by the GP. All changes in health status were documented and followed up. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed and the resident was waiting on reassessment for transfer to hospital level care.</p>

choice/needs.		
<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>	FA	<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 an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness which expires 7 June 2017. There is a maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius.</p> <p>PSC Kilmarnock Heights home is divided into five wings (neighbourhoods): Rata Lane, Kowhai Close, Kauri Place, Totara Terrace and Rimu Glen. Each neighbourhood has its own tea/coffee making facility.</p> <p>The physical environment with wide corridors and spacious rooms allow easy access and movement and promotes independence for residents with mobility aids. Handrails are appropriately placed in the corridors and communal areas. There is a large communal dining, recreational room, lounge areas and smaller areas for quiet activities and private meetings with family/visitors.</p> <p>The grounds are tidy, well maintained and able to be accessed safely. There is seating and shaded areas available. There is an internal courtyard. The residents interviewed advised they enjoy taking care of the internal gardens. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans</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</p>	FA	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. All bedrooms are single with their own hand basins. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>

requirements or receiving assistance with personal hygiene requirements.		
<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>	FA	<p>All bedrooms in all the facility are of an adequate size appropriate to the level of care provided. The bedrooms allow for the resident to move about the room independently with the use of mobility aids. 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>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</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 rest home has a large dining area, recreational room, large and smaller lounges with seating placed appropriately to allow for group and individual activities to occur. One smaller lounge is available for reading and quieter activities and church services. Residents are observed safely moving between the communal areas with the use of their mobility aids.</p>
<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>There are dedicated cleaning staff who have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All personal clothing and the facility laundry is laundered at the nearby PSC Cashmere facility. There is a small domestic laundry for kitchen washing only. Residents interviewed were satisfied with the laundry service.</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. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available</p>

		<p>always. 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>A section 31 notification was completed for the slip that occurred during the earthquake 4 days before the audit (sighted).</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 bedrooms and communal rooms have large windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The communal areas, corridors and bedrooms are heated with radiator heating and maintained at a comfortable temperature. Residents and relatives interviewed confirm the environment and the bedrooms are 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>	FA	<p>PSC Kilmarnock Heights has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The clinical nurse manager is the designated infection control coordinator with support from all staff as the quality management committee (infection control team). Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</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>	FA	<p>The clinical nurse manager is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p>	FA	<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</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>training and education of staff. The policies have been reviewed and updated.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator attends the PSC Infection Control Forum and is provided with education and updates through this forum. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in PSC Kilmarnock Heights infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Infection rates are low. A project was implemented to reduce the incidence of urinary tract infections and a reduction was evident. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There is a restraint policy in place that states the organisations philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there were no residents with restraint or enablers at PSC Kilmarnock Heights. Staff are trained in restraint minimisation and the management of challenging behaviour. The clinical nurse manager is the restraint coordinator for the service.</p>

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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 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>In all six files reviewed the clinical nurse manager or registered nurse had completed an initial assessment and initial care plan within 24 hours of admission. Four of six files reviewed had the initial interRAI assessment completed within the required timeframes.</p> <p>There was evidence that an improvement project around interRAI had been implemented and all residents are now entered on interRAI. Two of four residents due for a six-monthly review of their interRAI assessment had had these completed.</p> <p>The registered nurses update the long-term care plan with a change in health condition as evidenced in the files sampled. A project has been implemented to ensure that long-term care plans are evaluated in the required timeframes. Two of four long-term care plans due for review had six-monthly evaluations documented.</p>	<p>i) Two of six resident files had not had the initial interRAI assessments completed within 21 days of admission.</p> <p>ii) Four of six resident files had not had the interRAI assessment completed at last six-monthly.</p> <p>iii) Two of four long-term care plans (due for</p>	<p>i-iii) Ensure that all interRAI assessments and long term care plan reviews are completed within the required timeframes.</p> <p>90 days</p>

			review) had not been reviewed six-monthly.	
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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 1.3.7.1</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 has achieved all ten Eden principles in August 2106. The residents are actively engaged in the running of the home and report high levels of satisfaction with the recreational programme and philosophy of care.</p>	<p>The service has embedded the Eden philosophy of care and demonstrates a high level of Eden appropriateness. Residents are involved in site committees and residents contribute to meaningful activities within the home such as tending to the internal courtyard gardens and looking after the animals. Residents were instrumental in writing the PSC homes Standard of Conduct and Resident Rights which are now included in the admission agreement. Residents and staff hold a weekly focus meeting around the wellbeing domain. Eden principles are regularly reported on in the individual resident progress notes and clinical documentation reflects the Eden philosophy of care. Medication rounds no longer take place in the dining room.</p> <p>Residents are actively engaged in the wider community and host one morning a month at the community centre. Residents also provide baking to the local Cancer society. Families with young children are encouraged to visit the service and a children’s corner has been set up. Each neighbourhood of residents have a weekly ‘Catch up Cuppa’ with the recreational officer and management. Residents report a high level of engagement and satisfaction with how the service is run and enjoy the meaningful contribution they make.</p>

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End of the report.