

Presbyterian Support Central - Kandahar

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Presbyterian Support Central
Premises audited:	Kandahar Court Kandahar Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 3 April 2018 End date: 4 April 2018
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:	73

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Kandahar Home and Kandahar Court (Kandahar) 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 across two separate homes on different sites. Kandahar Home provides rest home and hospital level care for up to 63 residents and Kandahar Court provides secure dementia level care for up to 25 residents. Occupancy on the day of the audit was 73 residents in total (48 residents at Kandahar Home and 25 residents at dementia level care).

The facility manager at PSC Kandahar has management experience and has been in the role since November 2016. The facility manager is supported by a clinical nurse manager, two clinical coordinators and a regional manager. Residents interviewed spoke positively about the service provided.

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

The service has addressed the five shortfalls from their previous certification audit relating to incident reporting, incident data analysis, scheduled meetings, advance directives and restraint monitoring.

This audit has identified two further improvements required relating to the mandatory training and care plan interventions.

The service has continued to achieve a continuous improvement related to food services.

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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PSC Kandahar provides care in a way that focuses on the individual resident. The service ensures effective communication with all stakeholders including residents and families. There is a complaints policy to guide practice and this is communicated to resident/family.

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 a number of meetings including monthly senior team meetings. An annual resident and relative satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation, staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an

organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Registered nurses are responsible for each stage of provision of care. Assessments, care plans, interventions and evaluations have been completed within the required timeframes. Residents and family interviewed confirmed that the resident's needs/supports were being met. There is allied health professional input into the resident's care. Planned activities are appropriate to the resident's assessed needs and abilities. Activities are varied, interesting and meaningful for the residents as evidenced on resident/relative interviews. Medications are managed and administered in line with legislation and current regulations. The general practitioner reviews medication charts at least three-monthly. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are nutritional snacks available 24 hours.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Both facilities have current building warrant of fitness certificates.

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 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 are currently two hospital level residents requiring restraint and one resident using an enabler. Staff are trained in restraint minimisation.

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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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. There has been one outbreak that was well managed.

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	15	0	2	0	0	0
Criteria	1	38	0	2	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 1.1.10: 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>	<p>FA</p>	<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 on nine of nine resident files sampled (three hospital, one of which was palliative care, three rest home and three dementia care including one resident under a compulsory treatment order [CTO]). Resuscitation treatment plans were appropriately signed in the hospital and rest home files reviewed for residents deemed to be competent. Residents not competent to make decisions had medically indicated not for resuscitation status. The previous finding around resuscitation status for dementia care residents has been addressed.</p> <p>The GP documented discussions with the enduring power of attorney. The EPOA had been activated in two of three dementia unit files. A court order was in process for one resident under CTO. Discussion with rest home and hospital residents and relatives confirmed that the service actively involves them in decisions that affect their relative's lives. Five healthcare assistants, two enrolled nurses (EN) and the dementia unit clinical coordinator/RN interviewed confirmed an understanding around resuscitation processes. Care staff have attended an advance care planning education session June 2017 and the dementia care clinical coordinator has attended a DHB study day covering EPOA and advance directives.</p>
<p>Standard 1.1.13: Complaints</p>	<p>FA</p>	<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</p>

<p>Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>records activity. Complaint forms are visible around the facility. Four complaints (three in 2017 and one in 2018 year to date) have been made since the last audit in October 2016. The 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 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy. Six residents (one hospital and five rest home) 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. Fifteen incident forms reviewed for March 2018 identified family were notified following a resident incident. Interviews with healthcare assistants (HCA) confirmed that family are kept informed. Three relatives (one hospital, one rest home and one dementia) 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 every three months at Kandahar Home and relative meetings six-monthly at both Kandahar Home and Kandahar Court.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Kandahar 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 across two separate homes at two separate sites in Masterton. 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 73 residents. There were 34 rest home level residents, 14 hospital level residents, including 1 palliative care resident and 25 residents in the dementia care unit (including one resident under a CTO agreement). All other residents were on the aged related residential care (ARRC) agreement.</p> <p>The facility manager at PSC Kandahar has management experience and has been in the role since November 2016. The facility manager was absent at the time of the audit. The facility manager is supported by a clinical nurse manager, two clinical coordinators (one at Kandahar Home and one at Kandahar Court) and a regional 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 Kandahar Home clinical coordinator has been in the role for five months and the Kandahar Court clinical coordinator has worked at the service for over twenty years and five years in the dementia unit. The facility manager is supported by a regional manager who visits the site monthly.</p> <p>PSC Kandahar has a 2017–2018 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 and health and safety.</p> <p>The facility manager and clinical nurse manager have maintained at least eight hours annually of professional</p>

		development activities related to managing a care facility.
<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>	FA	<p>Presbyterian Support Central has an Enliven quality programme in place that includes internal benchmarking with the other PSC sites. There is an annual meeting schedule including senior team, staff, clinical/RN and health and safety meetings. Meetings have been held as scheduled. The previous finding around scheduled meetings has now been addressed. The senior team meeting acts as the quality committee and progress with the quality programme/goals are monitored and reviewed through the fortnightly senior team meetings. Information is fed back to the monthly clinical focused meetings and staff meetings. A range of other meetings is held at the facility as scheduled. Meeting minutes and reports are provided to the senior team meeting and actions are identified in quality improvement forms, which are being signed off and reviewed for effectiveness.</p> <p>There is an internal audit calendar in place and the schedule has been adhered to for 2017 and 2018 (year to date). Accident/incident data and analysis is shared with staff (discussed at staff meetings and placed on noticeboards). Corrective actions are signed out and evaluated for effectiveness. The previous finding around accident/incident data has now been addressed. 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.</p> <p>The service has a health and safety management system and this includes a health and safety rep (EN) that has completed health and safety training. Monthly reports are completed and reported to meetings and at the quarterly Health and Safety Committee meeting. There is an up-to-date hazard register which was last reviewed on 12 January 2018. A resident/relative satisfaction survey is completed annually. The 2017 survey informed an overall satisfaction with the service at Kandahar Home for residents at 81.25% and an overall satisfaction with the service for relatives at 77.77% for Kandahar Home and 66.67% for Kandahar Court. Corrective actions were established in areas identified as below the national average (eg, around food/meals and activities). 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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	FA	<p>The service collects a set of data relating to adverse, unplanned and untoward events. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Ten incident forms for Kandahar Home (hospital/rest home) and five incident forms for Kandahar Court (dementia care unit) for March 2018 were sampled. All incident forms have been fully completed and residents reviewed by a RN. Neurological observation forms were documented and completed for any unwitnessed falls with potential head injuries. Two pressure injuries identified in March 2018 (stage I) and in October 2017 (stage III) had completed</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>incident forms. The previous finding around pressure injury incident reporting has now been addressed. Discussions with the clinical nurse manager and confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. One section 31 notification has been completed since the last audit for a pressure injury (stage III) in October 2017.</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>PA Low</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 RNs, general practitioners and other registered health professionals are kept. Nine staff files were reviewed (one clinical nurse manager, one clinical coordinator, one RN, three HCAs, one cook, one recreational officer and one EN/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 coordinator at Kandahar Home recently completed an orientation programme. A training programme is being implemented for 2018, however, not all mandatory training had been completed over the last three years.</p> <p>Eight of eleven RNs are interRAI trained. Nineteen of twenty-three of the HCAs who are employed in the dementia care unit have completed their dementia specific units. The four HCAs that have not completed, have commenced work within the last 12 months and are in progress of completing.</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 coordinators work full-time. 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>At Kandahar Home, the facility manager, clinical manager and one clinical coordinator is based.</p> <p>In Kandahar Home, there are two hospital wings (Cunningham- 18 beds and West- 12 beds) and two rest home wings (East- 17 beds and Falloon- 16 beds). In the hospital wings, there are 14 hospital residents in Cunningham and there are 10 rest home residents in West. There is a unit coordinator, who is supported by one RN, one EN</p>

		<p>and two HCAs on the morning shift, one RN and two HCAs on the afternoon shift and one RN and two HCAs on the night shift.</p> <p>In the rest home wings, there are 8 rest home residents in East and there are 16 rest home residents in Falloon. There is one EN and three HCAs on the morning shift, one EN and three HCAs on the afternoon shift and one HCA on the night shift. During the night shift, a hospital RN provides oversight for the rest home.</p> <p>In Kandahar Court, there are two dementia care units (Court- 12 beds and House- t13beds). In the dementia units, there are 12 dementia residents in Court and there are 13 residents in House. There is a clinical coordinator assigned to the dementia unit who is supported by one RN and four HCAs on the morning shift, four HCAs on the afternoon shift and two HCAs on the night shift. During the afternoon and night shifts, a hospital RN provides oversight for the dementia care unit via the phone. One relative interviewed at Kandahar Court stated there was sufficient staff rostered in the dementia care unit.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	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 RN. Medications are stored safely at both sites. Registered nurses, ENs and HCAs who administer medications have completed medication competences and education on an annual basis. There are weekly checks of the hospital stock and emergency supplies. Medication fridges are monitored. There were no standing orders. There were four residents self-medicating (one hospital and three rest home) with current self-medication assessments that had been reviewed three-monthly by the GP. Eighteen resident's medication charts (four hospital, eight rest home and six dementia care) were sighted on the electronic medication system. All prescribing of regular and 'as required' medications met legislative requirements. The general practitioners review medication charts at least three-monthly.</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</p>	CI	<p>All meals are prepared and cooked on-site in the main kitchen in Kandahar Home. Meals are transported in a specialised van to Kandahar Court kitchen in insulated hot boxes. There is a five-weekly rotating winter menu in place that has been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen adjacent to the rest home dining room. The breakfast is self-service for those residents who can manage. The service is the first PSC facility to introduce self-service midday meals. Residents are assisted by staff with meals, as observed on the day of audit. There are two dining rooms at Kandahar Court with one being adjacent to the kitchenette, with meals served from the kitchenette. A bain marie is used for the second dining room. The food services team leader (interviewed) confirmed resident nutritional profiles are received and dislikes accommodated. Currently there are no special diets.</p> <p>There are nutritious snacks and finger foods available in the dementia unit kitchenette 24 hours. The cooks and kitchenhands have completed food safety and hygiene training. End cooked, delivery and serving temperatures are</p>

<p>delivery.</p>		<p>monitored and recorded. Fridge and freezer temperatures are taken and recorded daily. Cleaning schedules are maintained. The food control plan has been registered at head office 23 January 2018. 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. The service has continued to improve meal services with the self-service midday meal.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>When a resident's condition alters, a RN initiates a review and if required, GP or nurse practitioner 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; changes in medications; and challenging behaviours. Discussions with family members are documented in the health summary status notes and identified with a family contact stamp. There is input from the DHB psychogeriatric nurse who liaises and visits with the psychogeriatrician for residents 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 nine current wounds and for two residents with facility acquired stage I pressure injuries. There is evidence of DHB wound care nurse and district nurse involvement in the treatment of chronic wounds/pressure injuries as required. Residents are weighed monthly. Nutritional requirements and assessments are completed on admission identifying resident nutritional status. Monitoring forms used include (but not limited to): hourly night-time monitoring; behaviours; restraint; blood sugar levels; and monthly weights.</p> <p>Contenance products are available and resident files include urinary continence assessment, bowel management and continence products identified for use.</p> <p>Short-term care plans had been developed and reviewed for short-term changes to health and documented interventions to meet the residents needs/supports. Not all interventions had been documented to manage risks.</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</p>	<p>FA</p>	<p>There is a recreational team leader (35 hours per week) who oversees the activities programme for Kandahar Home (rest home and hospital) and Kandahar Court (dementia unit). She is supported by three part-time (and one casual) recreational officers. There are two part-time recreational officers providing activities Monday to Sunday 12.30pm to 5.30pm at Kandahar Court. The recreational team leader and a part-time recreational officer provide activities Monday to Friday 10am to 4.30pm at Kandahar Home. Resources are available at both sites for care staff to access when recreation staff are not on duty.</p> <p>There are separate programmes for rest home/hospital and dementia unit. Rest home/hospital activities include (but not limited to): exercises; crafts; bowls; newspaper reading; board games; music; flower arranging; and movies.</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>The Eden philosophy is implemented and residents' skills and abilities are celebrated and valued within the programme. One of the residents has their own art room and takes resident groups for arts and crafts. There are weekly scenic tours and monthly outings to the Golden Oldies music concerts. Community visitors include kindergarten children, college students, entertainers and pet therapy visitors. The PSC chaplain (interviewed) visits residents regularly at both facilities. Volunteers involved in the activity programme offer one on one time with residents including chats and reminiscing.</p> <p>Activities at Kandahar Court are focused on meaningful activities with a flexible programme that includes chats, reminiscing walking group, music therapist visits, sing-a-longs, baking, happy hours, one on one time with residents and outings.</p> <p>Each resident has an Eden "tree of life" in their resident file. The activity plan is based on companionship, usefulness, emotion, well-being and communication. The activities plan for residents in the dementia unit reflects activities which could be used to distract behaviours.</p> <p>Residents and families interviewed report satisfaction with the activities programme.</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 of permanent residents had been evaluated by a RN within three weeks of admission. A short-stay assessment and support plan was in place for the resident under palliative care. 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. Short-term care plans reviewed evidenced they had been evaluated and either resolved or added to the long-term care plan if the problem is ongoing. There are six-monthly written evaluations against resident goals. The multidisciplinary team (MDT) includes the RN, DT, GP, the nurse practitioner and resident/relative. The GP/NP reviews the resident at least three-monthly. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Kandahar Home and Kandahar Court buildings have a current warrant of fitness that expires 1 July 2018. The service has constructed an ambulance/van entrance with overhead canopy at the Kandahar Home facility. There is ongoing refurbishment as required.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (currently the clinical nurse manager) 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. The combined infection control/health and safety committee meeting is representative of each service area and includes representatives from Kandahar Court. Infection control data, trends and analysis is collated monthly and reported to the senior management and staff meetings. All infections are documented on the infection monthly online register and benchmarked against other PSC facilities. The surveillance of infection data assists in evaluating compliance with infection control practices. There has been one norovirus outbreak in September 2017 that affected both facilities. Relevant authorities were notified. The cause of the outbreak spread to both facilities was identified due to movement of staff between both facilities. There was a full report with CARs identified including incorrect use of PPE non-compliance of uniforms and staff training given.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service 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. At the time of the audit there were two hospital residents with restraints and one resident requiring the use of an enabler. Staff are trained in restraint minimisation.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>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 for the two residents with restraints, evidenced that monitoring was occurring in the timeframe prescribed to minimise the risks around the use of restraint. The previous finding around restraint monitoring timeframes has now been addressed.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	A training programme is being implemented for 2018; however, not all PSC mandatory training had been completed over the last three years.	The documented PSC mandatory three-yearly training had not been completed for cultural awareness, spirituality/counselling, Code of Rights, open disclosure, complaints, communication, end of life and challenging behaviour.	Ensure that all mandatory training is completed as per schedule. 90 days
Criterion 1.3.6.1 The provision of services and/or	PA Low	Residents where appropriate and family members confirmed the resident's needs were being met. Short-term care	(1) Falls prevention strategies/interventions had not been documented for two high falls risk residents (one rest home and one hospital). (ii) The hospital resident did not have the	Ensure interventions are

<p>interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>plans had been developed and reviewed for short-term changes to health and documented interventions to meet the residents needs/supports. Not all interventions had been documented to manage risks.</p>	<p>use of shin protectors documented. (iii)The same rest home resident did not have any pain management plan for hip pain (identified on admission) which affects their mobility and (iv) Two hospital residents on restraint did not have risks associated with the use of restraint documented in the care plan.</p>	<p>documented to meet the current health status of the residents.</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 five-weekly seasonal menu, which is reviewed by a dietitian and adapted to reflect resident preference. The service has continued to improve the service around meals that encourages choice and independence in line with the Eden philosophy.</p>	<p>Following the success of the buffet continental self-service breakfasts at Kandahar Home, the service was the first PSC site to introduce buffet self-service midday meals. The midday self-service meals have been in place since May 2017. There is a bain marie set into a table. The bain marie pots of food are kept hot during the meal service. Residents were seen to be able to freely mobilise with mobility aids around the bain marie table and able to reach the food safely. This self-service encourages residents to be independent and they have the choice of what they would like and portion sizes as desired. The food service team leader confirmed alternative foods are provided for dislikes. The care staff were seen to be serving meals for residents from the bain marie for those who were unable to participate in the buffet dining. Residents interviewed during the audit expressed satisfaction with being able to plate their own meals and enjoyed the meals offered. Resident meeting minutes evidenced resident satisfaction with the midday buffet meals. The November 2017 resident survey demonstrated an increase in resident satisfaction in food services from 3.35 in 2016 to 4.25 in 2017.</p>

consumer group.			
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End of the report.