

Presbyterian Support Central - Kandahar Court

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Presbyterian Support Central	
Premises audited:	Kandahar Court	
Services audited:	Dementia care	
Dates of audit:	Start date: 8 November 2019	End date: 8 November 2019
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:	25	

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
	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

Kandahar Court is part of the Presbyterian Support Central (PSC) organisation. The service provides dementia level care for up to 29 residents. On the day of the audit there were 25 residents.

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

The service is overseen by a non-clinical facility manager and a clinical nurse manager both of whom are well qualified and experienced for their roles. This management team also oversees Kandahar Home which is physically three minutes away. The facility manager and clinical nurse manager are supported by the clinical coordinator, registered nurses and the business operations manager. Residents and family interviewed spoke positively about the service provided.

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 relatives interviewed were familiar with the complaint's 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 Kandahar Court 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 relative satisfaction survey is completed and there are regular family meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented induction programme for all roles within the service. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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An admission package with information on services provided at Kandahar Court is available prior to or on entry to the service.

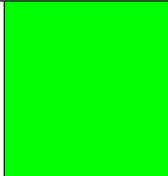
Registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Electronic resident files included medical notes by the general practitioner, nurse practitioner and visiting allied health professionals. There is a three-monthly nurse practitioner or general practitioner (GP) review.

The residents' activities programme provides diversional therapy activities, these include one-to-one and group activities, community involvement and outings.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete annual education and medication competencies. All medication charts have photo identification, allergy status and evidence of three-monthly reviews noted.

All meals are prepared and cooked at PSC Kandahar Home. There is a Food Control Plan in place. The five-weekly seasonal menu has been reviewed by a dietitian. Individual and special dietary needs and residents' dislikes are catered for, and alternative options are available for residents.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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PSC Kandahar Court has a current building warrant of fitness. All rooms are single, personalised, and have a hand basin, some rooms have ensuites. There is adequate room for delivery of dementia level of care within the resident's rooms. Residents can freely access communal areas using mobility aids. There are communal dining areas, recreational areas, several lounges and seating areas. Outdoor areas and the internal courtyards are safe and accessible for the residents. There is wheelchair access to all areas.

Housekeeping staff maintain a clean and tidy environment. All laundry is undertaken at Kandahar Home. Chemicals were stored safely throughout the facility. Appropriate policies are available along with product safety charts.

There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Appropriate training, information and equipment for responding to emergencies are provided. A van is available for transportation of residents.

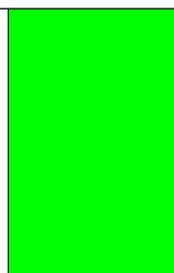
Systems are in place for essential, emergency and security services.

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. Other than the environmental restraint of the secure unit no restraint or enablers are used. Staff are trained in what restraint is and challenging behaviour management.

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)
Standards	0	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) has been incorporated into care. Discussions with six care staff identified their familiarity with the Code of Rights. Interviews with three 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.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Residents and their families are provided with all relevant information on admission. Policies and procedures for informed consent and resuscitation are in place. General consents and specific consents where applicable are obtained on admission and updated as required. These were sighted in the five dementia residents' files reviewed. Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) for care and welfare were all activated and sighted in resident files.</p> <p>Systems are in place to ensure residents' (where appropriate), and their family/whānau (where appropriate), are provided with appropriate information to make informed choices and decisions. Discussions with staff confirmed consent is obtained when delivering care. A signed admission agreement was in place for the files reviewed. Discussions with family/whānau confirmed that the service actively involves them in decisions that affect their relative's lives.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. The information pack provided to relatives at the time of entry to the service also provides family/whānau with advocacy information. Interviews with healthcare assistants and relatives informed they were aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Interviews with relatives 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 and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups as much as able.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice and this is communicated to family members/representatives. The facility manager leads the investigation and management of complaints (verbal and written). A complaint's register records activity. Complaint forms are available at the front entrance. Three complaints have been made in 2018 and 2019 year to date. The three complaints reviewed were appropriately investigated and resolved to the satisfaction of the complainant, any corrective actions identified were implemented. Discussion with relatives confirmed they were aware of how to make a complaint. A copy of the complaint's procedure is provided to relatives within the information pack at entry.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Code of Rights leaflets were available in the front entrance of the facility. Code of Rights posters were on the walls in the hallways. Client right to access advocacy services is identified for relatives and advocacy service leaflets were available at the front entrance foyer. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss. Families at interview confirmed they were informed of the scope of services and any liability for payment for items not included in the scope.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p>	FA	<p>There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people's beliefs and values. A tour of the facility confirmed there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the</p>

<p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>audit. Families interviewed confirmed that staff were respectful, caring and maintain their dignity, independence and privacy at all times. A review of documentation, interviews with relatives and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. The service's philosophy results in each person's cultural needs being considered individually. On the day of the audit, there was one respite resident that identified as Māori.</p> <p>A review of the current Māori Health Plan was undertaken with the goal to have a support plan that acknowledges the Māori resident's needs and the domains of wellbeing. All new residents will have a wellness map and this information will be used to ensure the support plan reflects the spiritual, cultural, physical and whānau wellbeing needs of each resident. The goal included being more alert to the cultural needs of residents and whānau by working together providing residents with a sense of belonging – a connection to their culture. The opportunity to be more culturally centred, identifying the purpose of the home/care and to make it adaptable for all cultures.</p> <p>Considerable work had been undertaken to establish close working ties with local Māori and identify what they wanted of aged care. Working with a group including a resident from a fellow home, whānau member and kaumātua as well as Māori staff members, management were able to get a global, holistic overview of "what mattered – what was important". A new training programme to fit into the three-year mandatory training cycle was created showing how easily the Eden alternative philosophy and domains of wellbeing align with cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the facility manager, clinical nurse manager or clinical coordinator along with the family/whānau complete the documentation. Family interviewed confirmed that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any</p>	<p>FA</p>	<p>Discrimination, coercion, exploitation and harassment policies and procedures are in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination-free environment. The Code of Rights is included in orientation and in-service training. Interviews with staff</p>

discrimination, coercion, harassment, sexual, financial, or other exploitation.		confirmed their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. In discussions with relatives they believed residents privacy is ensured.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care and dementia needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The relative satisfaction survey reflected high levels of satisfaction with the services that are provided. Relatives interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and dementia level care. Staff stated that they feel supported by the management team.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an open disclosure policy. Relatives interviewed stated they were welcomed on entry with their family member 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. Sixteen incident forms reviewed for October 2019 identified family were notified following a resident incident. Interviews with healthcare assistants confirmed family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. Discussions with family members confirmed they were given time and explanation about services on admission. Family meetings occur six-monthly.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Kandahar Court is part of the Presbyterian Support Central (PSC) organisation. The service provides dementia level of care for up to 29 residents. On the day of the audit there were 25 residents; one being a resident on respite. All residents were on the ARC contract. There is a non-clinical manager who has been in the position for three years. There is a clinical nurse manager (3.5 years in the role) and a clinical coordinator who provides support to the facility manager. The manager and clinical nurse manager also oversee the sister home – Kandahar Home which is three minutes away from Kandahar Court. The clinical coordinator at Kandahar Court is fulltime. The manager and clinical nurse manager are each at the site a day a week and as required. The manager also undertakes work for the site whilst based in his office at Kandahar Home. The clinical coordinator (based at Kandahar Court) has worked at the service for over eight years. The clinical coordinator from Kandahar Home also covers Kandahar Court for some on call and as the Infection Coordinator. The facility manager is supported by a business operations manager who visits

		<p>the site weekly.</p> <p>Kandahar has a 2019-2020 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, the Eden alternative and health and safety. Progress towards goals (and objectives) is reported through the manager reports taken to the monthly senior management team meeting.</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 (eg, annual leave) of the facility manager and would be supported by the business operations manager and the Presbyterian Support Central (PSC) office.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Presbyterian Support Central has an overall Quality Monitoring Programme (QMP) and PSC Kandahar Court participates in the PSC benchmarking programme. The senior team meeting acts as the quality committee and they meet twice a month. Information is fed to the monthly clinical focused meetings and staff meetings. The meetings are combined with meetings alternating between the sites (Kandahar Court and Home). There is an annual meeting schedule including staff (full facility) meetings. Staff meetings are held monthly. 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.</p> <p>Progress with the quality programme/goals has been monitored and reviewed through the twice monthly senior team meetings. There is an internal audit calendar in place and the schedule has been adhered to for 2019 (year to date). Data is collected in relation to a variety of quality activities, including accidents/incidents, falls and infection control. There is discussion around quality data trend analysis at staff meetings (and at handovers) along with progress in corrective action plans. The PSC organisation business operations manager directly oversees minutes, corrective action plans and progress. The service has a health and safety management system, and this includes health and safety representatives (clinical and non-clinical that are undertaking/completed health and safety training). Monthly reports are completed and reported to meetings and at the quarterly health and safety committee. Health and safety meetings include identification of hazards and accident/incident reporting and trends.</p> <p>The service has policies and procedures to provide assurance that it is meeting accepted good practice</p>

		<p>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. Policies and procedures are introduced to staff ensuring staff are kept up to date with the changes. An organisational staff training programme is based around policies and procedures. A relative satisfaction survey is completed annually. The 2018 survey informed an overall satisfaction with the service in line with PSC average, however only 6 out of 29 relatives responded. Some information from relatives was gained from relatives at meetings held in March and September (eight relatives attended each meeting). The response at each meeting was positive. The 2019 relative survey is due to be sent out November 2019.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	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 used for comparative purposes with other similar PSC services. Sixteen incident forms for Kandahar Court for October 2019 were sampled. All incident forms have been fully completed and residents reviewed by a registered nurse. There is documented evidence of relative notification (or documentation that relatives do not wish to be informed eg, if it is a fall with no injury) on all 16 accident/incident forms. Discussions with management confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There was currently one case before the coroner (sudden death and the resident's GP was away, so did not sign the death certificate).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process require that relevant checks are completed. A copy of qualifications and annual practising certificates including registered nurses, general practitioners and other registered health professionals are kept. Six staff files were reviewed (one clinical coordinator, two healthcare assistants, one recreational officer, one kitchen assistant and one cleaner). All staff files reviewed included the appropriate employment and recruitment documents including annual performance appraisals if due (4 not due).</p> <p>The clinical coordinator and the clinical nurse manager are interRAI trained.</p> <p>The service has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. A training programme is in place that includes eight hours of annual education. The registered and enrolled nurses attend PSC clinical and professional study days, which cover the mandatory education requirements and other clinical requirements. Attendance is monitored. The staff training plan includes regular sessions occurring as per the monthly calendar.</p>

		Thirteen of seventeen healthcare assistants who are employed in the dementia care unit have completed their dementia specific units. One other has done introduction to health sciences and along with the other three who have not been employed for six months, is enrolled to undertake the dementia specific units. Two recreation staff who have not been employed for six months are also undertaking the units.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager, clinical nurse manager and clinical coordinator work full-time. There is a registered nurse on daily (not including the clinical coordinator) for eight hours, seven days a week (for two days a week there are two RNs on). Agency staff are used to provide cover for sickness if necessary. The HCA numbers are adequate. Interviews with HCAs and family members identified 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. There are at least four HCAs/ENs on the AM, four on PM shifts and two on the night shift.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents' files are electronic (login access), and paper files are protected from unauthorised access by being locked away in the nurses' station. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Prior to entry to PSC Kandahar Court, potential residents have a needs assessment completed. The service has an admission policy, admission agreement and a resident information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of the service. Five signed admission agreements in the files reviewed aligned with contractual requirements. Exclusions from the service are included in the admission agreement. The clinical coordinator and a registered nurse described the entry and admission process.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer	FA	A transfer document, summary care plan and medication profile are electronically generated when residents are transferring to hospital. All relevant information is documented and communicated to the receiving health provider or service. Planned exits, discharges or transfers are coordinated in

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>collaboration with the family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The dementia unit has a separate medication room. The medication trolleys are securely locked, and the medication room temperature is monitored.</p> <p>Registered nurses, the enrolled nurse and/or medication competent carers administer medications from robotic rolls on medication rounds. These staff have been assessed for competency on an annual basis and attend annual medication education. RNs attend syringe driver education. All medication is checked on delivery against the electronic medication chart. All medications were securely and appropriately stored. There were no residents self-medicating on the day of audit. Policies and procedures were in place if there were any residents self-medicating. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening.</p> <p>Ten medication charts reviewed met legislative requirements; all charts had photo identification and allergies/adverse reactions noted, and 'as required' medications prescribed correctly with indications for use. Medications had been signed as administered in line with medication charts. The ten medication charts included three monthly GP reviews. Appropriate practice was demonstrated on the witnessed medication round. Controlled medication administration was fully documented.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals are prepared and cooked at PSC Kandahar Home. Daily hot food temperatures are taken and recorded for each meal. All meals are cooked and transferred to a bain marie. Meals are then trayed and put in a hot box and transported to Kandahar Court where meals are served to residents in the dining room or delivered on trays to residents in their rooms.</p> <p>The kitchen at Kandahar home was observed. The Food Control Plan expires on 23 January 2020. The food services team leader at Kandahar Home (a qualified cook), is responsible for the operations of food services. The kitchen team includes the food services team leader, a second cook and kitchenhands. There is a five weekly rotating summer and winter menu that is reviewed by the company dietitian. A food services policies and procedures manual is in place.</p> <p>All residents have their dietary requirements/food and fluid preferences recorded on admission and updated as required. The cook has access to the electronic patient management system and maintains a list of residents' dietary requirements that include likes/dislikes. Alternative choices are offered. The cook is informed of dietary changes and any residents with weight loss. Dietary needs are met including</p>

		<p>normal, pureed meals and finger foods. Specialised utensils and lip plates are available as required. Snacks are available for residents 24 hours a day.</p> <p>Food surveys provide relative feedback on the meals and food services. Relatives interviewed confirmed likes/dislikes are accommodated and alternative choices offered.</p> <p>Fridge and freezer temperatures are recorded. Dry foods in the pantry are dated and sealed. Perishable foods in the chiller and refrigerators are date-labelled and stored correctly. The well-appointed kitchen has a dishwashing area, preparation, cooking, baking and storage areas.</p> <p>Chemicals are stored safely. Safety data sheets are available, and training is provided as required. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves.</p> <p>It was proposed that the current main meal be moved to 1700 hours as opposed to midday. Open discussion with families and staff were held in order to gain feedback and to ascertain any concerns before trialling. The change was trialled across differing days to identify any issues that needed addressing – feedback was gained from staff from each trial. Changes were made from 23 September 2019 with outstanding approval of staff and residents that were able to express an opinion. The outcome: Residents are more settled in the evening and there is a decline in behavioural concerns; Residents sleep more soundly in the evening; Residents are more involved in the afternoons with the recreation programme and residents are eating larger meals than previously.</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>If entry is declined, the management staff at PSC Kandahar Court communicate directly with the referring agencies and potential resident or family/whānau as appropriate. The reason for declining entry to the service would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>There was evidence in files sampled that the RN completes an initial admission assessment within 24 hours which includes relevant risk assessment tools for all residents. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident/relative and significant others.</p> <p>All long-term resident files reviewed, included interRAI assessments. Additional assessments for management of wound care were appropriately completed according to need. The long-term care plans</p>

		reflected the outcome of the assessments. All files sampled including the respite resident's file had behaviour assessments in place.
<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 RN develops the long-term support plan from information gathered over the first three weeks of admission. Care plans are individually developed with the resident, and family involvement is included where appropriate. The RN is responsible for all aspects of care planning. Care plans included goals and specific interventions for all identified care needs. Assessments and care plans included input from allied health including the GPs, nurse specialist, and podiatry. Physiotherapy is available if needed.</p> <p>Care plans are updated with changes as they occur. Short-term care plans and wound management plans are integrated into the resident care plans and provide direction for care staff. Medical GP notes and allied health professional progress notes were evident in the residents integrated files sampled. The care plans were individualised, identified triggers and strategies and interventions for de-escalating behaviours of concern.</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>A health status summary held in the resident's electronic records documents significant events, investigations, GP visits and outcomes. The registered nurse initiates a review when there is a change in the resident's condition and arranges a GP or nurse specialist visit if required. There is evidence of three-monthly medical reviews, or the GP will visit earlier if there is a change in health status. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to residents' health status. Resident files sampled recorded communication with family.</p> <p>Staff reported there were adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted.</p> <p>There were 12 wounds and no pressure injuries being treated on the day of the audit. A sample of eight wounds were fully reviewed. Wound assessments had been completed; all wounds had individualised plans which were being followed. There was evidence of nurse practitioner and GP involvement and/or wound specialist nurse input. Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.</p> <p>Caregivers are alerted to the requirement to complete electronic daily monitoring and advised of specific resident needs at handovers. The active short-term care plans and long-term care plans are in the electronic resident care system. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts are completed as required.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a recreation team leader (based at Kandahar Home, that oversees activities in Kandahar Court) and two recreation officers, with one additional recreation officer available as required.</p> <p>The recreation team leader is currently completing DT training and is also currently studying level four in dementia training. The recreation team leader oversees the two recreation officers. The recreation officers are not trained as diversional therapists, they are currently undertaking their dementia training.</p> <p>Recreation officers provide activities seven days a week. The activities staff hours are 9.30am to 4.00 pm. After hours the health care assistants have activities, they access to provide activities for residents.</p> <p>A chaplain also provides spiritual and pastoral care to residents. There is one volunteer who plays the piano on a regular basis.</p> <p>The activities programme is displayed on a weekly calendar. It includes (but is not limited to) whiteboard games, crafts, reminiscing games, dominos, golf, music, ball handling, baking and church services. There are regular outings into the community with a recreation officer who has a first aid certificate.</p> <p>There is a range of activities to meet the recreational preferences and individual abilities of residents. One-on-one time is spent with residents who choose not to participate in the group programme.</p> <p>The activities officer completes a resident social profile and activities assessment and in conjunction with the RN they write the 24/7 activities plans in resident files on admission. Each resident's activity plan is reviewed six monthly. The relatives provide feedback on the programme through one-to-one feedback. The residents were sighted on the day of the audit participating in activities and relatives interviewed commented positively on activities offered.</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>Two of the five residents' files sampled had been in the facility for longer than six months. There was evidence in these files of evaluations of the support plan. There was at least a three-monthly review by the GP. Care plan reviews were signed by the RN in files sampled.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. A transfer document, summary care plan and medication profile are electronically generated when residents are transferring to hospital. There are documented policies and procedures in relation to exit, transfer or transition of residents. The relatives are kept informed of the referrals made</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>by the service. The RNs interviewed described the referral process to other medical and non-medical services.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The service has policies and procedures for the disposal of waste and hazardous material. There is an incident system for investigating, recording and reporting all incidents. The chemical supplies are kept in locked cupboards in service areas. The contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment (gloves, aprons, goggles) are readily available to staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current building warrant of fitness which expires 1 July 2020.</p> <p>The maintenance person visits the site Monday to Friday and carries out minor repairs, reactive and preventative maintenance. There is an annual maintenance plan, with monthly checks, which include hot water temperatures, maintenance of resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment is calibrated annually. Essential contractors are available after hours.</p> <p>Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained, and provided a spacious, safe, secure outdoor area for walking. There are outdoor areas with seating and shade. There is wheelchair access to all areas.</p> <p>There is key-pad entry to the facility and secure perimeter fencing .FM</p> <p>Bedroom doors have different colours to enable residents to recognise their rooms. E.g. one resident has a yellow door as this was that residents favourite colour</p> <p>A lighting plan was implemented two years ago with brighter lighting in the corridor and lights to enable depth perception.</p> <p>The facility has a van available for transportation of residents, with a current warrant of fitness and registration. Those staff transporting residents hold a current first aid certificate.</p> <p>The health care assistants and RNs stated they have enough equipment to safely deliver the cares as outlined in the resident care plans. There are adequate storage areas for hoist, wheelchairs, products and other equipment.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All resident rooms are single. There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Call bells are available in all toilet/shower areas. All bedrooms have a hand basin. Some resident rooms have an ensuite, some share an ensuite toilet and some residents use common area toilets and showers. There is an ensuite toilet that adjoins a male and a female resident's room; however, the door is bolted, to prevent the male accessing this toilet; and the male resident chooses to use the communal toilet which is well labelled. Family members interviewed confirmed their family members privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident rooms in the facility are of an adequate size for dementia level of care. The bedrooms allow for the resident to move about the room independently or with the use of mobility aids. The bedrooms have wide doors for ambulance or bed entry/exit. Residents and their families are encouraged to personalise the bedrooms as viewed.</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>There are three lounges and two dining areas to meet the needs of the residents. There is a courtyard and large outdoor garden area. The facility design allows for freedom of movement for all residents including those with mobility aids. Staff assist residents to access communal living areas as observed on the day of the audit.</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>All personal clothing and laundry are laundered off site at Kandahar Home. Dirty laundry is collected daily and clean laundry delivered daily. There is a defined clean and dirty area of the laundry and an entry and exit door. The sluice area and laundry have personal protective clothing available including gloves, aprons and face masks. Adequate linen supplies were sighted. There are policies and procedures which provide guidelines regarding the safe and efficient use of laundry services.</p> <p>Cleaners are rostered daily Monday to Sunday. The cleaners' cupboard containing chemicals is locked. Cleaners' trolleys are well equipped and kept in locked areas when not in use. All chemicals have</p>

		<p>manufacturer labels. Cleaning staff were observed to be wearing appropriate personal protective equipment. The environment on the day of audit was clean and tidy. There is a daily and monthly room clean schedule. The cleaning staff have completed chemical safety training.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. The facility is well prepared for civil emergencies and has civil defence kits (readily accessible) that are checked monthly. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, torches, batteries and radio.</p> <p>The backup generators are run for half an hour monthly. Emergency lighting is checked. There is a barbeque and gas bottles for alternative cooking source. The staff interviewed were able to describe the emergency management plan and how to implement this. Fire training and security situations are part of orientation of new staff. A minimum of one person trained in first aid is available at all times. There are call bells in the residents' rooms and lounge/dining room areas.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All resident rooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The facility is heated and kept at a comfortable temperature. The facility was at a warm and comfortable temperature on the day of the audit.</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</p>	FA	<p>The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. PSC use a software programme to assist with benchmarking of data. Summaries of these results are reported back through the senior management meeting and to the staff meetings. The scope of the infection control programme policy and infection control programme description is available. There is an implemented infection control programme that is linked into the risk management system. The infection control coordinator (registered nurse in the role of clinical coordinator) provides feedback at staff meetings. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation.</p> <p>The governing body are responsible for the development of the infection control programme and its</p>

scope of the service.		review.
<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>Infection control is discussed at monthly senior management/team leader meetings and staff meetings. The staff meetings are attended by a cross section of staff from all areas of the service including management, clinical, kitchen, cleaning, laundry and maintenance. The service also has access to the PSC clinical director and nurse consultant, the DHB infection control nurse specialist, public health and the GPs.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	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 training and education of staff. The policies have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator (registered nurse) had commenced in the role two weeks prior to audit. She had commenced the Ministry of Health online ICC training and was booked to receive a day of tutoring later in the month from the PSC IC nurse consultant. The infection control coordinator also has access to the microbiologist, pharmacist, DHB infection control nurse, Public Health, Med Lab, GPs, expertise within the organisation and external infection control specialists.</p> <p>The infection control coordinator provides infection control orientation to all new staff. Infection control education is part of the professional nurses and healthcare assistants study days that are held annually. Resident education is expected to occur as part of providing daily cares.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs at PSC Kandahar Court. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP and laboratory staff that advise and provide feedback/information to the service. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported to the senior management/team leader and staff meetings. The senior management/team leader meetings include the monthly infection control report. Individual resident infection control summaries are maintained. All infections are documented on the infection monthly online register. The surveillance of infection data assists in evaluating compliance with infection control practices. Short-term care plans were evidenced as completed for infections. There have been no outbreaks reported since previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has a 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. Other than the environmental restraint of a secure unit, nil restraint is used.</p> <p>Staff are trained in what restraint is, challenging behaviour and de-escalation and competencies are completed.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>Click here to enter text</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	Click here to enter text
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	Click here to enter text
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	Click here to enter text
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	Click here to enter text

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.

No data to display

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

No data to display

End of the report.