Presbyterian Support Central - Kowhainui Complex

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:	Kowhainui Complex
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 13 June 2019 End date: 14 June 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: 78

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

Kowhainui Enliven Complex is part of the Presbyterian Support Central organisation (PSC). The service provides rest home and hospital level of care for up to 79 residents. At the time of the audit there were 78 residents in total.

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, management, general practitioner and PSC chaplain.

The non-clinical facility manager has been in the role for 10 months and has business management experience in aged care. The facility manager is supported by an experienced clinical nurse manager who has been in the position for four years. The facility manager and clinical nurse manager are supported by two clinical coordinators and a team of registered nurses. Residents and family interviewed spoke positively about the service provided.

This audit identified there was not an approved fire evacuation.

The service has achieved continuous improvement ratings for recognition of Māori, health and safety, activities and meals.

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.

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 resident's individual, values and beliefs. Residents receive services in a manner that considers their dignity, privacy and independence. Policies are implemented to support residents' rights, communication and complaints management. The service promotes and encourages good practice. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

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.

Kowhainui home continues to implement the PSC quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to several meetings including senior team meetings, staff meeting and peer support meetings. An annual resident and relative satisfaction survey are completed and there are regular resident meetings and relative meetings. Quality performance is reported to staff at meetings and includes trends and analysis 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 and on-call over.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.

An admission package with information on the services provided at Kowhainui 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. Resident files included medical notes by the general practitioner and visiting allied health professionals. There is a three-monthly general practitioner (GP) review.

The residents' activities programme provides diversional therapy activities, and these are varied and 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 on site. 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 made 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Kowhainui has a current building warrant of fitness. All rooms are single, personalised, and have an ensuite. There is adequate room for the safe delivery of hospital and rest home level of care within the resident's rooms. Residents can freely access communal areas using mobility aids. There are communal dining areas, craft and recreational areas, and several lounges and seating areas. Outdoor areas and the internal courtyards are safe and accessible for the residents. There is wheelchair access to all areas.

Housekeeping staff maintain a clean and tidy environment. All laundry is completed at Kowhainui. 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. There is always a first aid trained staff member on duty.

A van is available for transportation of residents.

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.

There is a restraint policy in place that states the organisation's philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there were 11 residents with restraints and five residents using enablers. Consents, assessments, monitoring and evaluations had been completed as per policy. Restraint minimisation, enabler use, and challenging behaviour training is included in the training programme.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (RN) is responsible for coordinating education and training for staff. The infection control nurse has completed annual training. There is a suite of infection control policies and guidelines to support practice. The infection control nurse uses the information obtained through surveillance to determine infection control activities and education needs within the facility. There have been no outbreaks.

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	48	0	0	1	0	0
Criteria	4	96	0	0	1	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Interviews with 14 care staff; including two clinical coordinators, three registered nurse (RN), three enrolled nurses (EN) and six HCAs reflected their understanding of the key principles of the Code. Staff receive training about the Code as part of the mandatory training programme.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	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 were obtained on admission and updated as required. These were sighted in the nine residents' files reviewed (five hospital and four rest home files). Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) for care and welfare were in resident files for residents deemed incompetent to make decisions. Systems are in place to ensure residents, 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.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A policy describes access to advocacy services. Information about accessing advocacy services information is available in the main entrance. The information pack provided to residents at the time of entry to the service also provides residents and family/whānau with advocacy information. Interviews with healthcare assistants, residents and relatives informed they were aware of advocacy and how to access an advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Interviews with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going always of the day during the audit. Maintaining links with the community is encouraged such as senior net, age concern, Alzheimer's, cancer society and church groups. Discussion with staff, relatives and residents confirmed residents are supported and encouraged to remain involved with former community groups. Residents are involved in fundraising projects for the community such as a pink ribbon breakfast, and relay for life.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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) in consultation with the clinical nurse manager for clinical concerns/complaints. A complaint register (on-line) records acknowledgement of complaints, investigation and resolution including advocacy information within the required timeframes. Enliven compliments, concern and complaint forms are available in the facility. There have been two written complaints since the last audit both in 2018. The complaints reviewed were acknowledged, appropriately investigated and resolved to the satisfaction of the complainant within the required timeframes. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A copy of the complaint procedure is provided to residents within the information pack at entry.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of	FA	Code of Rights leaflets were available in the front entrance of the facility and posters were on the walls in the hallways. Client right to access advocacy services is identified for residents and advocacy information was available at the front entrance. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private on admission and at any other time as required. Interviews with seven residents (four rest home and three hospital) and three family members (one rest

their rights.		home and two hospital) confirmed that the service functions in a way that complies with the Code of Rights. One of the code of rights is discussed at each monthly resident meeting.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of peoples' 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 audit. Residents and families interviewed confirmed that staff were respectful, caring and maintain their dignity, independence and privacy at all times. A review of documentation, interviews with residents, relatives and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. The service's philosophy results in each person's cultural needs being considered individually. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with a local kaumātua who is readily available for resident, family and staff support. There are Māori staff who facilitate tikanga for the two Māori residents who identify with Māori. The two resident files reviewed identified the resident's ethnicity, iwi, hapu and marae. Their Māori culture and preferences were included in the resident profile and throughout the care plan. Staff interviewed were able to describe how they can ensure they meet the cultural needs of residents identifying as Māori. Treaty of Waitangi and cultural safety is included in the mandatory education programme.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The cultural service organisational policy guides staff in the provision of culturally safe care. During the admission process, the clinical nurse manager or registered nurses (RN), along with the resident and family/whānau identify the residents cultural and spiritual needs and document this in the care plan. Residents and family interviewed confirmed that they are involved in the development of the care plan including spiritual and cultural values and beliefs. Families are actively encouraged to be involved in their relative's care in whatever way they want and can visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. PSC Kowhainui employ a chaplain (interviewed) for 10 hours per week. The chaplain visits at least three times a week providing support to resident's, families and staff. The chaplain also coordinates other visitors for residents such as other religious denominations, counselling or social work services. The chaplain conducts church services in the on-site chapel.

Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Discrimination, coercion, exploitation and harassment policies and procedures are in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination free environment. The Code of Rights is included in orientation and in-service training. Interviews with staff confirmed their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. The code of conduct and confidential clause and information technology policy is signed on employment.
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. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. There are regular staff meetings and meeting/benchmarking information is available to staff as observed on the staffroom noticeboard. The PSC nurse consultants and clinical director have regular meetings with the management team and clinical coordinators and readily available at other times. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. The service demonstrates they are continually striving to provide quality care. Quality initiatives include changing the main meal to evening, buffet breakfasts, implementation of electronic resident care system, installation of Wi-Fi for resident/family use, development of a sensory room an implementation of the new Māori Health plan. The resident satisfaction survey reflects results above the PSC average levels of satisfaction with the services that are provided. Residents interviewed spoke very positively about the care and support provided.
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. Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services, and charges not included in the admission agreement. Electronic accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Nine incident forms reviewed for May and three in June 2019 identified family were notified following a resident incident. Interviews with RNs confirmed that family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. There are monthly resident and Eden meetings. Family meetings occur every three months to keep families informed on facility matters and provide a forum for general discussion. Enliven-wide and PSC Kowhainui newsletters are produced on a regular basis and displayed. The service has installed Wi-Fi throughout the facility to facilitate relative and resident communication. Interpreter services are provided as required.
Standard 1.2.1: Governance	FA	Kowhainui Complex is owned and operated by Presbyterian Support Central organisation. The service

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.		provides rest home and hospital level care for up to 79 residents. There are 11 dual-purpose beds within the hospital unit (Ata). On the day of the audit there was a total of 78 residents. There were 36 rest home residents (including two private paying boarders) in the 37-bed rest home unit (Ahiahi) and five rest home residents in the dual-purpose beds. There were 37 hospital residents including two residents under ACC contract, one younger person with a physical disability under MOH funding and three residents under DHB funded Intermediate Transitional Convalescent Short-Stay Agreement.

Presbyterian Support Central (PSC) has an overall business/strategic plan, philosophy of care and mission statement. Kowhainui has a facility-specific 2018-2019 business plan which links to the organisation's strategic plan and is reviewed at quarterly meetings in consultation with the management team and general manager and interim chief executive officer at head office.

Kowhainui business goals include: 1) reducing impact on the environment by increasing recycling and reducing waste such as replacing polystyrene cups with paper cups, 2) increasing Māori culture and awareness with the introduction of an organisational Māori health plan that aligns with the Eden principles and 3) to be valued as a provider of excellent care by stakeholders as demonstrated by very good occupancy and above average survey results. The service has achieved the 10 principles of the Eden philosophy.

The facility manager (non-clinical), holds a business management qualification and has been in the role since August 2018 and previously held a general manager and business and finance role for two aged care facilities. The facility manager reports to the general manager at head office and attends the PSC manager meetings held three times a year. The manager is supported on site by an experienced clinical nurse manager who has been in the role four years. There are two clinical coordinators (rest home and hospital).

The facility manager has completed more than eight hours of professional development relating to the management of an aged care service in the past twelve months including attending the PSC manager peer support meetings, leadership training, University of Tasmania Dementia education, "leading the walk" through the DHB and Eden associate training. The facility manager attends the three-monthly ARC forums at the DHB.

The clinical manager has completed leadership and quality training through the clinical managers peer support meetings. She has completed a postgraduate diploma in aged residential care in 2018. |
| Standard 1.2.2: Service Management

The organisation ensures the day-to-day operation of the service is managed in an | FA | The clinical nurse manager who is employed full time, covers the facility manager absence with support from the general manager and administrator. The clinical coordinators cover the clinical nurse manager leave. The clinical nurse manager and clinical coordinators provide on-call for clinical matters and the facility manager for non-clinical matters. |

efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		
Standard 1.2.3: Quality And Risk Management Systems

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service has a quality and risk management system in place. PSC has an overall Quality Monitoring Programme (QMP) that is part of the quality programme. Interviews with the facility manager and clinical nurse manager reflected their understanding of the quality and risk management systems that have been put into place. The senior team meeting acts as the quality committee and progress with the quality programme/goals are monitored and reviewed through the senior team one and two meetings. Topics relating to internal audits, human resource/staff issues, corrective action plan updates, health and safety, Eden activity and resident/relative issues, clinical/business risk, complaints, policies, restraint, infection control, incident data, education/training and business plan goals are discussed. Information is fed back to the monthly clinical meetings and general staff meetings. Quality data including infections, accidents/incidents, health and safety, audit outcomes, quality improvements and complaints/compliments are discussed at meetings and documented in meeting minutes. Six healthcare assistants (HCA) and three enrolled nurses (EN) confirmed they have access to meeting minutes.

There are policies and procedures documented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. Policies and procedures are reviewed by relevant personnel at head office and relevant advisory groups in consultation with facility managers and clinical managers. A document control system to manage policies and procedures is in place.

The quality and risk management programme includes an annual survey. The 2019 resident and relative satisfaction results for Kowhainui were both above the PSC overall average. The quality data is collected on the Leecare electronic resident management system. Data is analysed for trends and corrective action plans developed for any data outside of the PSC key performance indicators (KPI). Organisational benchmarking occurs against other facilities in the group. Internal audits have been completed as scheduled. Audit outcomes are discussed, and corrective actions put in place including re-audits for results less than expected. The service is active in initiating quality improvements. Examples include a sensory garden which is currently under construction, implementation of after-hours security tags and now trialling electronic laundry tags for clothing.

The service has a health and safety management system which includes health and safety committee meetings every three months. The facility manager is currently the health and safety officer. There are seven health and safety representatives across the services. Five representatives have completed either stage one or two of the health and safety training. A health and safety representative (interviewed) is involved in the orientation of new staff around health and safety, hazard management and fire safety. There |

		is a current hazard register, last reviewed March 2019. The committee reviews accidents/incidents and reported hazards.
		Falls prevention strategies are in place including the analysis and the identification of falls prevention strategies including staff observation, sensor mats, post falls reviews. Resident interventions are on a case-by-case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting 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.	FA	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. Twelve incident forms were reviewed including falls (witnessed and unwitnessed), skin tears, behaviours and near misses. All incident forms had been fully completed on Leecare and residents reviewed by a RN. Progress notes detailed RN follow-up, corrective actions and relative notification. Neurological observation forms were sighted on the electronic system and completed for unwitnessed falls with potential head injuries. Discussions with the facility manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been five section 31 notifications since the last audit for stage three and unstageable pressure injuries and one wandering resident involving the police. There have been no outbreaks since the last audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources management policies are in place, which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity, evidenced in the 11 staff files selected for review (one clinical coordinator, three RNs, one enrolled nurse one diversional therapist, three healthcare assistants, one cook and one cleaner/laundry person). All files contained a completed orientation and current performance appraisal. Care staff interviewed stated that they believed new staff were adequately orientated to the service. Copies of practising certificates for RNs and allied health professionals were sighted. Staff complete competencies and self-learning packages relevant to their role. The service has a group of volunteers who complete induction, have references, signed volunteer agreements and volunteer job descriptions. Healthcare assistants are supported to complete the New Zealand Certificate in Health and Wellbeing qualifications. An in-service education programme is being implemented that incudes mandatory training days for RNs and HCAs and other support staff. Staff are required to attend the study days which includes speakers, the clinical consultants and management team providing education. Individual record of training attendance is maintained. Records of attendance at the training days demonstrates that all staff attend as

		required. There is additional education offered though the DHB, hospice, dementia educator and company representatives. The safe manual handling sessions are taken by a clinical coordinator who has been certified to provide the training. Enliven has a professional development recognition programme for RNs and enrolled nurses that has been approved by nursing council. Senior RNs hold portfolios such as infection control, restraint, cultural, health and safety and palliative care and attend relevant peer support days. Eight of ten registered nurses and one enrolled nurse are interRAI trained. The service employs a first year of practice (FYOP) nurse graduate who works alongside a RN on duty.
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. Sufficient staff are rostered to manage the care requirements of the residents. The facility manager and clinical nurse manager work full-time Monday to Friday and cover the on-call with the clinical coordinators. The registered nurse clinical coordinators (one rest home and one hospital) work five days - one from Tuesday to Saturday and one from Sunday to Thursday. There are two RNs on morning shift and two RNs on afternoon shift. The afternoon RN from 1.00 pm to 9.30 pm works across the rest home and hospital. There is an enrolled nurse seven mornings a week in the rest home and hospital.

The rest home unit – Ahiahi has 37 beds with 34 rest home residents and two private paying boarders. There are five HCAs (three full shift and two short shifts with one finishing at midday and one at 2.30 pm. On the afternoon there are three HCAs (two on the full shift and one finishing at 10.00 pm). There are two HCAs on the full night shift.

The hospital unit – Ata has 42 beds including 11 dual purpose beds. There are five rest home residents in dual beds and 37 hospital residents. There are eight healthcare assistants (four full shift, three finishing at 2.30 pm, and one finishing at midday). On an afternoon shift, there are six healthcare assistants (two full shifts, two finishing at 9.30 pm, one finishing at 10.30 pm and one finishing at 8.00 pm). There is one HCA on night shift (as well as the RN). and two short shifts). On nights, there is one healthcare assistant (and one RN).

Extra staff can be called on for increased resident requirements. There are adequate staffing resources to cater for a change in acuity and occupancy. The service is actively recruiting staff to cover one RN maternity leave position and one HCA vacancy. Part-time staff work additional shifts as available. There is no agency available.

There are designated activity staff and cleaning and laundry staff. There are dedicated food services staff.

Interviews with residents and family members identified that staffing is adequate to meet the needs of residents. |

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 protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. The electronic resident management system is password protected and identifiable by date, time and writer. Policies and procedures are available A-Z on the intranet and in hard copy.
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 Kowhainui, 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. Nine admission agreements viewed were signed. Admission agreements in the files reviewed align with contractual requirements. Exclusions from the service are included in the admission agreement. The clinical nurse manager and clinical coordinators described the entry and admission process.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	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 collaboration with the resident and 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.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. The rest home and hospital areas have separate medication rooms. The medication trolleys are kept in locked rooms. Controlled drugs in both medication rooms are stored in a locked safe. Registered nurses, enrolled nurses or medication competent carers administer medications from blister packs on medication rounds. These staff have been assessed for competency on an annual basis and attend annual medication education. RNs and ENs 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. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. Eighteen 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 18 medication charts included three monthly GP reviews. Appropriate practice was demonstrated on the witnessed medication round.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are prepared and cooked on site at Kowhainui. The Food Control Plan expires on 23 January 2020. The Food Services Team Leader, a qualified chef, is responsible for the operations of food services. The kitchen team includes two weekend cooks 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 are in place. All residents have their dietary requirements/food and fluid preferences recorded on admission and updated as required. The cook maintains a folder 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 normal, pureed meals and finger foods. Specialised utensils and lip plates are available as required. Input from residents and food surveys, provide resident feedback on the meals and food services. Residents and relatives interviewed confirmed likes/dislikes are accommodated and alternative choices offered. Daily hot food temperatures are taken and recorded for each meal. A bain marie is used to deliver foods to the dining room. Holding temperatures are taken. 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 kitchen has a separate dishwashing area, preparation, cooking, baking and storage areas. The chemicals are stored safely. The chemical supplier completes quality control checks on the sanitiser. Safety data sheets are available, and training provided as required. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their	FA	If entry is declined, the management staff at Kowhainui 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.

family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	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. Of the nine files reviewed, three residents (not under the ARC) did not require interRAI assessments. Six long-term residents under the ARC had interRAI assessments completed within the required timeframe. Additional assessments for management of wound care were appropriately completed according to need. The long-term care plans reflected the outcome of the assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The RN develops the long-term support plan from information gathered over the first three weeks of admission. The resident support plan has categories of care that include hygiene and grooming, skin and pressure area care, elimination, mobility, nutrition and fluids, sleep, communication, vision, memory, behaviour, spirituality/faith and culture, medical (includes medication and pain management). All residents had a tree of life that outlined their personal story and likes and dislikes. The support plans sampled reflected the outcomes of risk assessments. Interventions clearly described support required. Each resident file sampled had a risk summary and detailed the resident's medical problems and alerts such as high falls risk. There was documented evidence of resident/relative/whānau involvement in the support planning process. The resident on an intermediate transitional convalescence short stay agreement has a short stay care plan and is being regularly seen by a physiotherapist for rehabilitation. The YPD resident has a care plan that is specific to a younger person; the activities plan focused on activities specific to this resident and included participation in bowls and movies. Short-term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short-term care plans sighted included management of skin infections and wounds, and behaviour management. There was evidence that short-term care plans sampled had been evaluated at regular intervals and integrated into the long-term care plan if an ongoing problem. Medical GP notes and allied health professional progress notes are evident in the residents integrated files sampled.

| Standard 1.3.6: Service Delivery/Interventions

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | 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.

Staff reported there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted.

There were 19 wounds and one pressure injury being treated on the day of the audit. Five hospital residents had eight wounds; one resident had a pressure injury. In the rest home six residents had 11 wounds. Wound assessments had been completed for all wounds. There was evidence of GP involvement and district nurse involvement for the pressure injury which was stage 3 for which a section 31 was completed. There was evidence of GP involvement and/or wound specialist nurse for eight of the residents with wounds. Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.

Behaviour management plans are developed with multi-disciplinary input and describe types of behaviour, possible triggers and interventions. The GP initiates any specialist referrals to the mental health services.

Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity and nutrition. Caregivers interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions. The active short-term care plans and long-term care plans are in the electronic software system used for resident care.

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 in use. |
| Standard 1.3.7: Planned Activities

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. | CI | The service employs a recreation team leader who leads a team of four; two diversional therapists (DTs), and two support people. The team provide activities across the rest home, hospital, day-care and villas. A chaplain also provides spiritual and pastoral care to residents. There are ten volunteers who work with recreation staff to provide entertainment and events to residents, games, craft, outings and events. There are three canine friends who have been visiting the residents for several years.

The activities programme is displayed on a weekly A3 calendar with large font. It includes (but not limited to) chair exercises, newspaper reading, baking, and mini golf. Speakers have included personnel from a mobility aids company, funeral directors, a legal firm and St John's. Activities have included an Easter |

| | | bonnet parade and a high tea for International Women's Day. Residents from Kowhainui created a korowai for the Cancer Society Relay for Life: Whanganui. Each resident involved in making the cloak made a feather with the name of a significant person on it, these feathers were all incorporated into the korowai. Each resident participating in the relay wore the korowai as they walked around the track.

The activity team have initiated several new meaningful integrated activities in consultation with the residents. The residents have the opportunity to provide feedback on the programme through resident and Eden circle meetings and survey results. The residents and relatives interviewed commented positively on activities offered. |
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| Standard 1.3.8: Evaluation

Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Five of the nine residents' files sampled had been in the facility for longer than six months. There was evidence in these files of six-monthly evaluations of the support plan. The resident/family interviewed advised that they are notified of reviews and are involved in care plan reviews. The long-term support plans reviewed evidenced that the support plan was amended with each review if there were changes identified. Short-term care plans reviewed were evaluated regularly with problems resolved or they were integrated into the long-term support plan if there was an ongoing problem. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | 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 residents and their families are kept informed of the referrals made by the service. The RNs interviewed described the referral process to other medical and non-medical services. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, | FA | 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 chemicals supplies are kept in locked cupboards in service areas. A chemical spills kit is available. 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. |

infectious or hazardous substances, generated during service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current building warrant of fitness which expires 22 June 2019. An invoice for the Compliance Schedule for the renewal of the Building Warrant of Fitness Annual Fee, dated 26 May 2019, was sighted. The maintenance person is employed 15 hours per week. The maintenance person carries out minor repairs and maintenance, reactive and preventative maintenance. There is an annual maintenance plan, with monthly checks, which include hot water temperatures, testing the generators, 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. The corridors are wide and promote safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas. 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. The caregivers 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. There is a designated internal vented smoking area and an external area.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal	FA	All resident rooms are single with hand basins and ensuites. There are adequate communal toilets. The ensuites have appropriate flooring and handrails. There are vacant/occupied signs and privacy locks. Call bells are available in all toilet/shower areas.

hygiene requirements.		
Standard 1.4.4: Personal Space/Bed Areas

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All resident rooms in the facility are of an adequate size for rest home or hospital level of care. The bedrooms allow for the resident to move about the room independently or with the use of mobility aids. The hospital bedrooms are spacious enough to manoeuvre hoists and hospital level lounge chairs. The bedrooms have wide doors for ambulance or bed entry/exit. Residents and their families are encouraged to personalise the bedrooms as viewed. Residents interviewed confirmed their bedrooms are sufficiently spacious and they can personalise them as desired. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The facility has separate rest home and hospital dining areas with open plan lounge rooms. Seating is placed appropriately to allow for groups and individuals to relax or take part in activities. The wide corridors are light and spacious and have seating and small tables placed to create additional lounge space. Residents were observed safely moving between the communal areas with the use of their mobility aids. There is adequate space within the hospital communal areas for the easy manoeuvre of specialised lounge chairs. There is a craft room, library and several small lounge areas for quiet activities and private meetings with family/visitors and an on-site chapel. |
| Standard 1.4.6: Cleaning And Laundry Services

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All personal clothing and laundry are laundered on site. There is a laundry person seven days a week from 8.30 am to 4.00 pm. There is a defined clean and dirty area of the laundry and an entry and exit door. The laundry is well equipped, and the machinery is regularly serviced. Personal protective clothing is available including gloves, aprons and face masks. Adequate linen supplies were sighted. New laundry trollies are in use with clean linen on for each wing. There are policies and procedures which provide guidelines regarding the safe and efficient use of laundry services.

Cleaners are available from 8.00 am to 7.30 pm. This ensures cleaners are on site to clean the many communal living areas and toilets, room cleans and clean and re-set the dining room after the evening meal. The cleaners' cupboard containing chemicals is locked. Cleaners' trolleys are well equipped and kept in locked areas when not in use.   All chemicals have 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. |
| Standard 1.4.7: Essential, Emergency, And Security | PA Moderate | There is an emergency management business management plan in place (which links to the DHB emergency plan) to ensure health, civil defence and other emergencies are managed. Emergency flip |

Systems Consumers receive an appropriate and timely response during emergency and security situations.		charts are displayed in staff areas. Staff interviewed were able to describe the emergency management plan and how to implement this. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is always on duty with a current first aid certificate. The fire evacuation plan is awaiting approval following remedial work to the fire walls. Records of six-monthly fire evacuations were sighted. A contracted service provides checking of all facility equipment including fire equipment. The service has alternative cooking facilities (two barbeques and gas bottles) in the event of a power failure. There are two portable generators on site. There is enough water with an on-site water well, food (including dehydrated foods), and civil defence supplies including walkie talkies and batteries. There are back-up hard copies of electronic medication charts and resident care plans. There are call bells in the residents' rooms, ensuites and communal areas. Residents were observed to have their call bells in close proximity. Some residents wear pendants call bells. Afternoon and night shift complete security rounds of the facility. The facility is secure after-hours.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All resident rooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The facility is heated and kept at a comfortable temperature. Residents and relatives interviewed confirmed the environment and the bedrooms are warm and comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control coordinator is a RN who has been in the role three years and has a current job description. She is supported by the clinical manager. Infection control reporting is integrated into the senior team meeting for discussion around events, trends and corrective actions. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. The programme is reviewed annually in consultation with all PSC infection control coordinators peer support day held with the PSC clinical director and nurse consultant last in September 2018. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. There is enough personal protective equipment available. Residents and staff are offered the influenza vaccine. There have been no outbreaks.

Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control coordinator has attended the annual infection control coordinators peer support group within the organisation that includes in-service, review of policies/procedures, infection control programme and sharing of information/experiences. The infection control coordinator has access to expertise within the organisation, DHB infection control nurse specialist, public health, GPs and laboratory service.
Standard 3.3: Policies and procedures 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.	FA	The infection control manual outlines a range of IC policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. The infection control policies and procedures are developed and reviewed by the organisational policy review group.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Infection control education is part of the annual education schedule. All staff complete infection control education and workbook on orientation. Registered nurses and enrolled nurses complete self-learning packages. Infection control is discussed at all facility meetings and at handovers. Hand hygiene audits are completed annually. There is an infection control board in the staffroom with notices, meeting minutes, staff newsletters and graphs to keep staff informed on infection control matters. Resident education is expected to occur as part of daily activities.

Standard 3.5: Surveillance	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources and education needs at Kowhainui. Internal infection control audits also assist the service in evaluating infection control needs. A monthly collation of reported infections (on Leecare) is analysed with trends and corrective actions identified. Surveillance data is discussed at senior team meetings and clinical meetings.
Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		
Standard 2.1.1: Restraint minimisation	FA	The service has policies and procedures to support of the use of enablers and restraints. The policy meets the intent of the restraint minimisation standards. The clinical nurse manager is in the enabler and restraint coordinator role and has a job description which defines the responsibility of the role. There were 11 hospital level residents with restraint (three residents had two restraints) and five hospital residents with enablers (two residents have two enablers). Voluntary consents and assessments for three enablers were up to date. The enabler is reviewed three monthly as part of the GP three monthly review. Risks associated with the use of enablers have been identified in the assessment and documented in the care plan.
Services demonstrate that the use of restraint is actively minimised.		
Standard 2.2.1: Restraint approval and processes	FA	The role and responsibility for the restraint coordinator is included in the restraint policy. The clinical nurse manager attends quarterly peer support meetings where restraint approval processes, policies and discussion are held around restraint minimisation. Lap belts, safety harness and bedrails are approved restraints. Registered nurses complete a restraint self-learning package on orientation and ongoing education is included in the education planner. Care staff also complete self-learning packages. The restraint minimisation and enabler policy clearly describe responsibilities for staff. Restraint minimisation, enabler training and challenging behaviour is included in the education planner.
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.		
Standard 2.2.2: Assessment	FA	The restraint coordinator undertakes restraint assessments in consultation with the clinical coordinators, GP and in partnership with the resident (as appropriate) and family/whānau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety. Assessments reviewed for three residents on restraint (two residents had two restraints) were reviewed and
Services shall ensure rigorous assessment of consumers is undertaken, where indicated,		

in relation to use of restraint.		all were completed as required and to the level of detail required for the individual residents. Completed assessments considered those factors listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation are included in the restraint policy. There are approved restraints documented in the policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or whānau/EPOA, GP and the facility restraint coordinator. Monitoring is documented as instructed and sighted in the electronic restraint files reviewed.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three monthly as part of the ongoing review for the residents on the restraint register, and as part of the care plan and GP review.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint use in the facility is evaluated in the monthly senior team meeting and annually. The restraint coordinator provides monthly restraint and enabler reports to the facility manager. Policies are reviewed by the policy review group at head office in consultation with enabler and restraint coordinators. Internal restraint audits identify any areas for improvement. Restraint is discussed at clinical meetings and at handovers. There have been no incidents relating to restraint use.

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 1.4.7.3 Where required by legislation there is an approved evacuation plan.	PA Moderate	Remedial work required to the fire walls had been completed and the service is awaiting an approved fire evacuation plan.	The service installed Wi-Fi throughout the facility which resulted in non-compliance of the ceiling fire walls. Remedial work has been completed, but the service has not received fire service approval of the fire evacuation plan. The email correspondence including application to the fire service for an approval was sighted on the day of audit.	Ensure there is an approved fire evacuation plan in place. 30 days

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
Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.	CI	The Māori Health plan has been implemented at Kowhainui and was reviewed in one of the two Māori residents file. The second Māori Health plan was in progress for the other Māori resident. Staff interviewed stated they feel engaged and connected with Māori residents incorporating their cultural wishes into delivery of all aspects of care. The resident and relative 2019 survey around cultural and spiritual needs was 4.27 and above the PSC average of	The PSC cultural advisory group was formed in 2018 to develop a Māori Health plan incorporating principles of Eden philosophy. This has been developed in partnership with kaumātua, whānau, residents and staff. There were six members of the cultural advisory group with connections to Kowhainui including the facility manager, Māori resident, Māori staff, volunteer, whānau and local kaumātua. Consultation meetings were held including a two-day hui at Ratana Pa and presentations made to the local marae and cultural groups and the DHB and has been well received. The Māori Health plan is on display in the facility. The DT and residents have created a feather cloak to be used in farewelling deceased residents from the home. A water bowl for the washing of hands and cleansing ritual is placed outside the deceased resident's room. The service offers on site (upstairs) accommodation for families. One of the volunteers who was part of the cultural advisory group had carvings commissioned and donated which are on display in recognition of Kowhainui's connection with the Māori people of Whanganui.

		4.00.	
Criterion 1.2.3.9

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented. | CI | The service identified a potential safety risk for staff, family and residents entering the service after the auto doors of the afterhours entrance closes at 7.00 pm. Access was by call bell. Due to the large facility and staff being involved in resident cares, answering the doorbell could be up to 10 or more minutes. In April 2019 the service introduced a security tag system which has been beneficial and provided security for residents returning from evenings out with their families and for families staying in the on-site accommodation. | In April 2019 the health and safety committee initiated a project to provide secure afterhours access to the facility for residents/family and staff. This followed concerns from: 1) family returning their loved ones from an evening out, 2) staff coming onto night duty and 3) family/whānau using the on-site accommodation. Delays in responding to the call bell meant those waiting were feeling unsafe and exposed to the weather while waiting. Security tags were introduced for access to the facility through the afterhours entrance. These are issued and signed out/into family/whānau taking out their loved ones for the evening. A security tag reader at the entrance to the door monitors the use of the tags. Comments from staff and resident meeting minutes have been positive. The security tags provide freedom, independence, autonomy and greater security with no delay in entry to the facility. Care staff can continue with their resident cares without interruptions to answer the doorbell. Accommodation guests are provided with instruction tags. The 2019 resident and relative survey result around the environment was above the PSC average. The health and safety project was nominated for the PSC Quality and Innovation award in May 2019 and Kowhainui was awarded runner-up at the awards night. |
| Criterion 1.3.13.1

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | A self-serve buffet unit was implemented in July 2018. The serving of the main meal was changed from midday to the evening and served at 5.30 pm. The lunchtime meal is now the light meal. The roster was changed and now the cook is on site from 9.15 am to 5.45 pm and prepares and oversees the | Following feedback from residents, Kowhainui increased the fresh food options for light meals (i.e., reducing use of processed foods) and diversified the meals to include meals that would appeal to a broader ethnic range. A rest home resident interviewed spoke positively about the "breakfast group". This resident spoke about the pleasurable breakfast times where residents help one another in serving breakfast and stack their plates afterwards, just like they would have in their own homes.

More residents now attend the dining room in the evening rather than having trays in their rooms. Residents are now more likely to go out during the day and return later as they are not going to miss out on the main |

		lunchtime and main meal which has led to improved quality of meals and no longer any reheated meals. Following feedback from residents, Kowhainui increased the fresh food options for light meals (i.e., reducing use of processed foods) and diversified the meals to include meals that would appeal to a broader ethnic range.	meal. More residents are inviting family and friends to join them for a meal. It has been noted there is an increased alertness and attendance at afternoon recreation activities and more social interaction at mealtimes. The Kowhainui resident survey results for satisfaction with meals in 2018 was 4.00 and in 2019 had increased to 4.41 (the Enliven average was 3.92 for 2019).
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	The activity programme across the facility is resident-focused and planned around meaningful everyday activities. The programme is supported by 10 volunteers. There is evidence that the residents have regular input into review of the programme (via Eden circles and resident surveys) and this feedback is considered in the development of the resident's activity programme. Survey results evidence resident satisfaction in the activities offered including new initiatives.	Community integration occurs in multiple ways. The wider Kowhainui community, rental flats and village folk are involved in recreation activities, mealtimes and general use of the home and communal areas, creating a hybrid community for all. In consultation with residents, family and staff, the Collier Lounge was converted into a Tavern type space which has increased usage of this lounge. The adjoining Montessori childcare pre-schoolers visit once a week for one hour on Thursdays. Spontaneous van activities enable residents to access community activities that include churches; concerts; and plays at the opera house. A sensory room was developed. A number of staff attended 'Walking in Another's Shoes', a resident-centred dementia care programme run through WDHB. The participants were keen to create a sensory room after learning the benefits and visiting one in the hospital. A plan was implemented, the room created, aids purchased, initial training was provided, and more training is planned. The training will include opportunities for use, integration into care plans and documentation of effectiveness of the sensory room. Kowhainui resident survey results have shown an increase from 2018 to 2019 in the following areas: cultural and spiritual; activities; and social needs. This rating is higher than the Enliven national average. The results are as follows: activities rating was 3.83 for 2018; 4.23 for 2019 and 3.68

			for the Enliven average. The social needs rating was 3.92 for 2018; 4.51 for 2019 and 4.01 for the Enliven average.

End of the report.