

# Presbyterian Support Central - Kowhainui Complex

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## Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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: 28 October 2021      End date: 28 October 2021

**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:** 77

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

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 77 residents in total.

This unannounced surveillance audit was conducted against a subset of 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, and general practitioner.

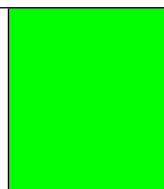
The facility manager has been in the role for three years and has business/management experience in the aged care sector. She is supported by an experienced clinical nurse manager/registered nurse (RN) who has been in the role for six years. The facility manager and clinical nurse manager are supported by two clinical coordinators/RNs (one rest home, one hospital). Residents and family interviewed spoke very positively about the services being provided.

One shortfall identified at the previous certification audit around a fire evacuation plan is now being met by the service.

This surveillance audit identified four improvements required in relation to staff orientation, reference checking, conducting annual performance appraisals and medication management.

## 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.

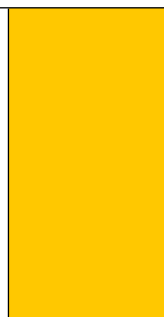


Standards applicable to this service fully attained.

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. 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.



Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Kowhainui home continues to implement the PSC quality and risk management system that supports the provision of care to its residents. Key components of the quality management system link to the range of meetings that are held on a regular basis. Annual resident and relative satisfaction surveys are completed and there are regular resident and relative meetings. Quality performance is reported to staff at meetings and includes trends and analyses of incidents, infections, and internal audit results. There are human resources processes established that cover recruitment, selection, orientation, staff training and development. The staffing policy aligns with contractual requirements and includes skill mixes and on-call cover.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Registered nurses and enrolled 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.		Standards applicable to this service fully attained.
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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. Outdoor areas and the internal courtyards are safe and accessible for the residents.

There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. An approved fire evacuation plan is in place. Appropriate training, information, and equipment for responding to emergencies are provided. There is a first aid trained staff member on duty at all times, including when taking residents on outings.

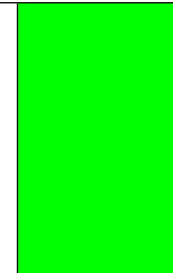
## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a restraint policy in place that states the organisation's philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there were nine residents with restraints and seven residents using bedrails as enablers. 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 coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking against other facilities in the group. There are organisational Covid-19 prevention strategies in place.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	15	0	0	2	0	0
<b>Criteria</b>	0	42	0	2	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy is being implemented. The facility manager has overall responsibility for ensuring all complaints (verbal and written) are fully documented and investigated. She maintains a complaints' register. Concerns and complaints are discussed at relevant meetings.</p> <p>Three complaints were lodged in 2020 and four complaints have been lodged in 2021 (year to date). Acknowledgement of each complaint and an investigation and communication with the complainant were documented and retained in the register. All complaints received were documented as resolved. Interviews with residents and relatives confirmed they have been provided with information on the complaints process.</p> <p>Evidence was sighted of complaints being discussed in staff meetings and corrective actions (where identified) implemented.</p> <p>There were no complaints from external authorities lodged with the service since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	<p>FA</p>	<p>Five residents (two rest home level including one young person with a disability (YPD), and three hospital level) and three relatives (rest home level) interviewed, stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incident/accident forms reviewed (15) indicated family/enduring power of</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>attorney (EPOA) were informed. Relatives interviewed confirmed they are notified of changes in their family member's health status and of any adverse event. Interpreter services are available as needed.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Kowhainui is owned and operated by Presbyterian Support Central (PSC). The service provides rest home and hospital (including medical) levels of care for up to 79 residents. There are 11 dual-purpose beds in the hospital wing.</p> <p>On the day of the audit there were 77 residents (43 rest home level and 34 hospital level). Four residents (one rest home and three hospital) were under the young person with a disability (YPD) contract and one resident (hospital) was on a DHB funded intermediate transitional convalescent short-stay agreement. The remaining residents were under the age-related residential care (ARC) agreement.</p> <p>The PSC organisation has a strategic plan, philosophy of care and mission statement. Kowhainui has a facility-specific annual business plan which links to the organisation's strategic plan and is regularly reviewed. The service has achieved the 10 principles of the Eden philosophy.</p> <p>The facility manager (non-clinical) holds a business management qualification, has been in the role since August 2018 and previously held a general manager and business and finance role for two aged care facilities. She is supported by an experienced clinical nurse manager who has been in the role six years, and two clinical coordinators (one rest home and one hospital).</p> <p>The facility manager and clinical nurse manager have completed more than eight hours of professional development relating to their respective roles.</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</p>	<p>FA</p>	<p>The service has a quality and risk management system being implemented. Interviews with the facility manager and ten staff (one clinical coordinator/RN, two staff RNs, one enrolled nurse (EN), four healthcare assistants (two rest home, two hospital), one food services team leader, one recreational team leader) 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 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</p>

<p>continuous quality improvement principles.</p>		<p>and documented in meeting minutes. Staff confirmed they have access to meeting minutes.</p> <p>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 nurse managers. A document control system to manage policies and procedures is in place.</p> <p>Quality data is collected via an electronic resident management system (Leecare). Data is analysed for trends and corrective action plans developed for results that fall outside of the PSC key performance indicators (KPIs). Organisational benchmarking occurs against other facilities in the group. Internal audits were being completed as scheduled. Audit outcomes are discussed, and corrective actions put in place including re-audits for results less than expected. The quality and risk management programme includes annual resident and relative surveys. The last survey results (June 2020) reflect high levels of satisfaction with the services received. No corrective actions were indicated. The service is active in initiating quality improvements. Examples since the last audit include a newly renovated medication room, a shop for residents and new flooring in the kitchen.</p> <p>The service has established a health and safety management system. There is a current hazard register that is regularly reviewed. Health and safety is discussed in the monthly staff meetings. Quarterly health and safety meetings are linked to staff meetings. Missing was evidence of health and safety orientation for contractors and students (link 1.2.7.4). Staff and families are provided with security tag access to the facility 24/7. A security tag reader at the entrance to the door monitors the use of the tags. 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.</p> <p>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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the</p>	<p>FA</p>	<p>The service collects a set of data relating to adverse, unplanned, and untoward events. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Fifteen incident forms were reviewed including falls (witnessed and unwitnessed), skin tears, behaviours, pressure injuries and bruising. All incident forms reviewed had been fully completed. Progress notes detailed RN follow-up, corrective actions, and relative notification. Neurological observation forms, sighted on the electronic system, were completed for unwitnessed falls and any incident with a potential injury to the head.</p> <p>Discussions with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications since the last audit have been completed for</p>

<p>service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>stage three and unstageable pressure injuries. There have been no outbreaks since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Human resources management policies are in place, which includes the recruitment and staff selection process. Seven staff files were reviewed (two healthcare assistants (HCAs), one kitchen hand, one cleaner, one recreation coordinator, one clinical coordinator/RN, and one EN). Relevant checks to validate the individual's qualifications, experience and veracity indicated that reference checking is not being documented. Two of the files were missing evidence of completing their orientation programme and the remaining files were missing evidence of a job-specific orientation. Annual performance appraisals are behind schedule. Copies of practising certificates for health professionals (internal and external) were sighted. Staff complete competencies and self-learning packages relevant to their role.</p> <p>An in-service education programme is being implemented that includes mandatory training days for RNs and HCAs and other support staff. Staff are required to attend the study days which includes external speakers, clinical consultants, and the management team. Individual records of training attendance are maintained. Records of attendance at the training days demonstrates that staff attend as required. There is additional education offered (e.g., DHB, hospice, dementia educator and company representatives). HCAs are supported to complete the New Zealand Certificate in Health and Wellbeing qualifications. Fourteen HCAs hold a level two qualification, seventeen hold a level three qualification and two hold a level four qualification. Eleven nursing staff (eight RNs and three ENs) are interRAI trained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. 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 four days a week (10 hours/day for hospital coordinator and eight hours/day for rest home coordinator). They share weekend cover (weekend on and weekend off). They also share a Tuesday (during doctor rounds and meetings).</p> <p>RN/EN staffing: There is one staff RN on the AM shift and one staff RN on the PM shift (based in the hospital wing). A third RN covers the rest home and hospital wings from 1300 to 2130. There is also one EN on the AM shift in the rest home and hospital. One RN covers the night shifts.</p> <p>The rest home unit – (Ahiahi) has 37 beds with 36 rest home residents at the time of the audit. There are five HCAs</p>

		<p>(three long [eight hour] shifts and two short shifts) on the AM shift. On the PM shift there are three HCAs (two long and one short). There are two HCAs on the night shift.</p> <p>The hospital unit – (Ata) has 42 beds including 11 dual purpose beds. There were 7 rest home residents and 34 hospital residents. There are eight HCAs (three long, five short). On the PM shift, there are six HCAs (two long and six short). There is one HCA on night shift (in addition to the RN).</p> <p>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 one staff to cover one RN position and with a full complement of HCA staff at the time of the audit. Part-time staff work additional shifts as available. There is no agency available.</p> <p>There are designated activity, cleaning, and laundry staff. There are also dedicated food services staff.</p> <p>Interviews with residents and family members identified that staffing is adequate to meet the needs of residents.</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>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management. 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.</p> <p>Registered nurses, enrolled nurses or medication competent HCAs 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 stored, and medication room temperatures were recorded as required. There were no residents self-medicating on the day of audit and no standing orders were used. The medication fridge temperatures are not always recorded within the timeframes as required. All eye drops, and ointments were dated on opening.</p> <p>Twelve electronic 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, however this was not always evident in the accompanied medication register. The twelve medication charts included three monthly GP reviews. Appropriate practice was demonstrated on the witnessed medication round.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>All meals are prepared and cooked on site at Kowhainui. The Food Control Plan expires on 22 January 2022. The food services team leader, a qualified chef, is responsible for the operations of food services. The Food Services Team Leader is supported by a cook's assistant 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>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>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. Healthcare assistants prepare modified liquids.</p> <p>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.</p> <p>Daily hot food temperatures are taken and recorded for each meal. There is a dining room adjacent to the main kitchen with a self-serve buffet.</p> <p>A bain marie is used to deliver foods to the dining room where food will be served by the healthcare assistants where residents are supervised or assisted with eating. Holding temperatures are taken. A thermotray service is also available for residents that enjoy their meals in their rooms. 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.</p> <p>The chemicals are stored safely. The chemical supplier completes quality control checks on the sanitiser. 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>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<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 are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted.</p> <p>There were 24 wounds and two pressure injuries (both hospital level residents, stage two on the sacrum) being treated on the day of the audit. There were fifteen wounds recorded for fourteen hospital level residents and nine wounds recorded for six rest home residents. In the rest home six residents had 11 wounds. The registered nurses confirmed that stage three pressure injuries are referred to a district nurse for review and involvement and a section 31 will be completed. There was evidence of GP involvement and/or wound specialist nurse for one hospital level resident with chronic lower leg ulcers.</p> <p>Wound assessments had been completed for all wounds. Wound care related documentation includes wound</p>

		<p>assessments, dressing charts and monitoring and evaluation records. Wound management plans are either recorded in the long-term care plan for chronic ulcers and pressure injuries or in a short-term care plan for skin tears.</p> <p>Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury. Healthcare assistants interviewed confirmed sufficient equipment is available for pressure relieving and include air alternating mattresses and roho cushions. Staff receive annual education in continence management and wound care management.</p> <p>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.</p> <p>Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity and nutrition. Healthcare assistants 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 system used for resident care.</p> <p>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.</p> <p>Falls preventions strategies are implemented and individualised to the need of the resident. YPD residents' long-term mobility, seating and postural support needs are assessed with the resident (where able) and their family/whānau.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a recreation team leader who leads a team of three; one qualified diversional therapist (DT) and two enrolled to complete a DT qualification. The team provides activities across the rest home and hospital. An Enliven chaplain also provides spiritual and pastoral care to residents and is part of the multidisciplinary reviews (as required). There is one volunteer who assists with van drives.</p> <p>There is a shop available for general items to be purchased and a hair salon that is operational three days a week. Several small lounges are available for private conversations or a quiet space and two big lounges for communal activities. There is also a chapel on site.</p> <p>The activity programme across the facility is resident-focused and planned around meaningful everyday activities. The activities programme is displayed in big print on noticeboards throughout the facility. It includes (but not limited to) chair exercises, newspaper reading, baking, bingo, mini golf. Special events include ANZAC day, annual market day, sweepstakes, and Melbourne Cup. The activity team have initiated several new meaningful integrated activities in consultation with the residents. There are several active groups and include a women's and men's group. The kaumātua group who assisted with cultural displays for Matariki and Waitangi Day, had a recent boil up and assist other residents with using poi as a form of exercise.</p>

		<p>There have been limitations to maintain the previous community links with the adjacent Montessori childcare centre due to Covid-19 restrictions. There is a sensory room that provides a quiet space for residents. One YPD resident confirmed they are assisted to go home on weekends and the staff are supportive of them to maintain community links.</p> <p>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.</p> <p>Activities care plan documentation is completed as required and includes a tree of life that includes cultural beliefs, life experiences and community involvement. An Enliven pilot study is in the infant stadium where all residents require an Oranga Kaumātua (wellness map) completed that is based on the Eden Alternative model and Te Whare Tapa Whā and include spiritual, emotional, physical, family, and social domains. All residents in Kowhainui participated, results were not yet available to capture the impact on resident outcome and will be available at the next audit.</p> <p>Attendance is recorded in the progress notes. The recreational leader interviewed confirmed activity staff are part of the six-monthly multidisciplinary review and have input into the interRAI assessments.</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>Five of the six 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 against the individual goals and current interventions. 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 were available for infections, reviewed and were evaluated regularly with problems resolved or they were integrated into the long-term care plan.</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 22 June 2022.</p> <p>Maintenance staff are contracted. A reactive and preventative maintenance programme is in place. The annual maintenance plan includes monthly checks (e.g., hot water temperatures, testing the generators, maintenance of resident equipment and safety checks). Electrical equipment has been tested and tagged within the past year. Clinical equipment is calibrated annually. Essential contractors are available after hours (link 1.2.7.4).</p> <p>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.</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>Care staff 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>There is a designated internal vented smoking area and an external area.</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>There is an emergency business management plan in place (which links to the DHB emergency plan) to ensure health, civil defence and other emergencies are managed. Emergency flip 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 (RN or EN) is always on duty with a current first aid certificate. The fire evacuation plan was approved on 20 August 2019. The shortfall identified at the previous audit has been addressed. Records of six-monthly fire evacuations were sighted. A contracted service provides checking of all facility equipment including fire equipment.</p> <p>The service has alternative cooking facilities (two barbeques and gas bottles) in the event of a power failure. There are portable generators on site. There is enough water with an onsite 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.</p> <p>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 a pendant call bell.</p> <p>Afternoon and night shift complete security rounds of the facility. The facility is secure afterhours.</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 (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 is analysed with trends and corrective actions identified. Surveillance data is discussed at senior team meetings and clinical meetings. Infection rates are benchmarked across the organisation. There have been no outbreaks at the facility since the last audit.</p> <p>There is a comprehensive Enliven Covid-19 risk response per phase or risk level. Staff are required to be fully vaccinated, using masks and were observed practising good hand hygiene. Relatives, visitors, and contractors are required to complete a Covid-19 symptom declaration on entry and required to wear masks. Relatives interviewed confirmed they are fully informed of the visiting requirements and residents receive continuous advice around hand washing and preventative measures. Staff interviewed confirmed they have sufficient supplies of PPE stock available.</p> <p>There are clear guidelines available for cleaning between equipment use, touch screen devices for sign in, and</p>

		tablets for accessing resident records and medication charts and reusable eyewear.
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	The service has policies and procedures to support of the use of enablers and restraints. An RN is responsible for the restraint programme but was unavailable for interview. The clinical coordinator (rest home) was able to fill this role during the audit. There were nine hospital level residents with restraint (bed rails and/or lap belt) and seven hospital level residents with an enabler (bedrails). Voluntary consents and assessments for the 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 are identified on each assessment and in the care plan.

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	The facility manager and clinical nurse manager are responsible for the appointment of new staff. The facility manager interviewed stated that this includes reference checking but that this process is not being documented.	Documented evidence of reference checking prior to the appointment of a new staff was missing in all seven files reviewed.	<p>Ensure that there is documented evidence of reference checking prior to the appointment of new staff.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an</p>	PA Moderate	HCA interviews confirmed that they receive a comprehensive orientation to the service that includes being buddied with more experienced staff. Two staff files (HCAs) were missing evidence of their completed orientation programme. The facility manager	i) Two of two HCA files selected for review were missing evidence of their	i) Ensure systems are implemented to monitor the

<p>orientation/induction programme that covers the essential components of the service provided.</p>		<p>stated that it is difficult to get these back from the HCAs after completed. Also missing was evidence of job-specific orientation for staff and health and safety orientation for external contractors and students.</p> <p>Staff are orientated to health and safety processes, but external contractors and students do not undergo a health and safety orientation programme prior to commencing work at the facility.</p>	<p>completed orientation programme.</p> <p>ii) Files reviewed for the clinical coordinator/RN, kitchenhand, cleaner, and recreation coordinator lacked specificity related to their job role and responsibilities.</p> <p>iii) External contractors and students do not receive a health and safety orientation prior to commencing work.</p>	<p>completion of HCA orientation.</p> <p>ii) Ensure all staff are orientated to their specific job role and responsibilities.</p> <p>iii) Ensure external contractors and students undergo an orientation to the facility's health and safety programme.</p> <p>60 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>A robust education and training programme is in place for staff that includes in-service training, professional development, and competencies. HCAs are encouraged to complete a Careerforce qualification in health and wellbeing.</p> <p>Staff who have been employed for over one year were missing evidence of a regular (annual) performance appraisal.</p>	<p>Five of five staff who have been employed for over one year did not have a current (annual) performance appraisal. The facility manager is aware of this gap and has a corrective action plan in place to address this finding.</p>	<p>Ensure all staff undergo regular performance appraisals as per the PSC policies and procedures.</p> <p>90 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>There is a comprehensive Enliven medication management policy. Registered nurses check medication on arrival and sign on the electronic chart. Any discrepancies are fed back to the pharmacy and recorded as a medication error. Medication is appropriately disposed of. Both medication rooms had recorded room temperatures. The fridge temperature in the rest home was consistently recorded however the fridge in the hospital (with insulin) was inconsistently recorded for a period (July-September). When temperatures were recorded for the hospital fridge (including on the day of the audit) all temperatures were within the acceptable range.</p> <p>Documentation where medication requires a second checker and signature was not always completed. Electronic medication charts were completed with a second checker and signature for rest home and hospital level residents, however the accompanied register available in the hospital had three recent entries without a second signature.</p>	<p>i) The medication fridge temperatures were inconsistently recorded for the period between July and September.</p> <p>ii) The medication signing sheet in the controlled drug register has not been fully completed.</p>	<p>i) Ensure medication fridge temperatures are recorded consistently within the stated timeframes in the policy.</p> <p>ii) Ensure the controlled drug register is fully completed to meet legislative requirements.</p> <p>60 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.