# Knox Home Trust Board

## 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 The DAA Group 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Knox Home Trust Board

**Premises audited:** Elizabeth Knox Home and Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical

**Dates of audit:** Start date: 25 March 2015 End date: 27 March 2015

**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:** 172

# 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 |
|  | 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

Elizabeth Knox Home and Hospital is owned and operated by a charitable trust. The organisation provides rest home and hospital level care for up to 192 older residents as well as younger people under the age of 65 living with a physical disability.

A full certification audit was conducted against the Health and Disability Services Standards and the services’ contract with the Auckland District Health Board. The audit process included an offsite review of the organisational polices and the onsite audit included the review of documentation, observations and interviews. The documentation review included a selected number of rest home and hospital residents’ files. Interviews were conducted with the owner, managers, staff, residents, family/whanau and general practitioners to verify the documented evidence. This audit report is an evaluation of the combined evidence on how the service meets each of the standards.

The chief executive, care director and clinical mentors are appropriately qualified and experienced for the roles they undertake. The strengths of the organisation are their implementation and international recognition as a fully registered Eden Alternative home. The integration of the Eden Alternative philosophy into the organisational goals and direction, the international recognition of the chief executive officer and the household model of care and the volunteer programme have gained a continuous improvement rating.

There are three areas for improvement related to the documentation of medicine management and the review and quality processes of the restraint minimisation programme. The strengths of the service include how the service provided flexible and individualised care to the younger and older residents.

## Consumer rights

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| --- | --- | --- |
| 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. |

Staff demonstrated good knowledge and practice of respecting residents’ rights in their day to day interactions with residents. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. Residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect. The organisation has a resident committee, and key workers with advocacy roles, for the younger residents living with a physical disability.

There were residents who identified as Maori residing at the service at the time of audit. There were no known barriers to Maori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

Written consents are obtained from the resident’s enduring power of attorney (EPOA) or appointed guardian, as required. Processes were in place for advance care planning and palliative care.

The organisation provides services that reflect current accepted good practice, as demonstrated in the guidelines for care of the aged person, the Eden Alternative and resident centred care. There is regular in-service education and staff access external education that is focused on aged care and best practice.

Management and staff communicate effectively with residents and their family/whanau and provide an environment conducive to good communication.

The service has a documented complaints management system implemented. There were no outstanding complaints at the time of audit.

## Organisational management

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| --- | --- | --- |
| 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

The organisation's values, goals and mission statement are identified in the business plan. Planning covers business strategies for all aspects of service delivery in a coordinated and cooperative manner, where staff partner with residents to ensure the residents’ needs are met. The service incorporates the Eden Alterative and the ‘Household’ model of care into the delivery of care and services. The service is rated beyond the full attainment (continuous improvement) for the way in which the governing body of the organisation, through the Eden Alternative, ensures services are planned, coordinated, and appropriate to the needs of residents.

The quality processes around projects are undertaken effectively to provide safe service delivery and are a particular strength of the organisation. Quality and risk management systems include the internal audit process, complaints management, resident and family/whānau satisfaction surveys and incident/accident and infection control data collection. The board and subcommittee of the board have a strong input into the review of the quality and risk data. Quality and risk management activities and results are shared among staff, residents and family/whanau, as appropriate.

The organisational policies reflect current accepted good practice. At the time of audit there were some policies and documents past their review dates. The organisation is continuing to implement their transition plan for the updating and reviewing of all policies and clinical documents to an electronic format, when this is completed all policies will be up to date.

The day to day operation of the facility is undertaken by staff and volunteers that are appropriately experienced, educated and qualified. There is well documented orientation, induction and ongoing performance reviews of staff. Human resources management processes implemented identify good practice and meet legislative requirements.

The service implements the documented staffing levels and skill mix to ensure the residents’ needs are met. The staffing and skill mix is reflective of the Eden Alternative philosophy of a household model of care. In each household, there are an adequate number of clinical mentors, care partners, life enhancers, household staff, and volunteers who assist in providing resident centred care. In addition to the staffing in each household, there are educators, physiotherapy, occupational therapy and kitchen staff within the organisation. The household model of care and the volunteer programme are rated as continuous improvement.

Resident information is uniquely identifiable, accurately recorded, stored securely to ensure it cannot be sighted by the public but is easily accessible to staff.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

The entry criteria for the service is clearly documented and communicated to the potential resident, family/whānau and referring agencies. If entry to the service is declined, a record is maintained and the potential resident and/or their family/whānau referred to a more appropriate service.

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. Residents receive timely, competent, and appropriate services which meet the Eden Alternative philosophy of care principles, and have all their needs met. Residents decide on the goals they want to reach and the service puts in the interventions to assist the resident to meet their goals.

The processes for nursing assessment, planning, provision, evaluation, review, and exit is provided within timeframes that safely meets the needs of the residents and contractual requirements.

The care plans describe the required support and/or intervention to achieve the desired outcomes. The provision of services and interventions is consistent with, and contributes to, meeting the residents' needs. Where progress is different from expected, the service responds by initiating intervention changes which are shown on the care plan or with the use of short term care plans.

Resident support for access or referral to other health and/or disability service providers is appropriately facilitated. Documentation reviewed identified, documented, and minimised risks associated with each resident’s transition, exit, discharge or transfer.

The service provides a planned activities programme to develop and maintain skills and interests that are meaningful to the resident. This includes residents working with a volunteer to maintain their interests and skills.

Staff responsible for medicine management are assessed as competent to perform the function for each stage they manage. Not all actions are clearly documented in the medication folder. This includes standing orders and these are areas requiring improvement to meet legislation and best practice guidelines.

Food services are contracted. All processes are managed to ensure residents’ food and fluid requirements are met. The residents reported high levels of satisfaction with the food services.

## Safe and appropriate environment

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| 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. |

The facility is large and purpose built. The newer areas have been designed to incorporate the home like philosophies of the Eden Alternative. All areas of the building, facilities, furnishings and equipment are well maintained and suitable. Applicable building regulations and requirements are met. Well-furnished and designed households and community areas, lounges, kitchen, dining, laundry and family areas are accessible to residents. The facility has plenty of natural light and is maintained at a comfortable temperature. A variety of bedrooms are provided. Each area is sufficiently sized to allow for safety, personal possessions and accommodates the residents’ needs. Safe and accessible external areas are available.

Cleaning and laundry services meet infection control requirements. The collection, storage and disposal of waste are in accord with infection control principles and council requirements. Staff comply with safe waste and hazardous substances processes.

Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. There are adequate numbers of staff trained in first aid and emergency situations on duty at all times. The organisation has appropriate stores and equipment in the event of an emergency. The building has an approved fire evacuation plan.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of low risk. |

There are policies and procedures on the use of restraints and enablers. Policies include clear definitions of the two, and how they can be used in a safe manner. The use of enablers is voluntary. Restraint use is keep to a minimum and, if considered appropriate, assessed and approved by the restrain team. Restraints are used in a safe manner and the required monitoring of each episode of restraint is maintained.

Restraint and enabler use is reviewed in an on-going manner; however improvements are required to the review and evaluation processes. This includes the individual review of restraint use and the regular evaluation of restraint practice for the organisation.

## Infection prevention and control

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| --- | --- | --- |
| 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 service provides a managed environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined, with the infection control coordinators reporting monthly to the board of trustees. The infection control programme is led by the infection control team but all staff are responsible for reporting infections.

There is a clearly defined infection prevention and control programme for which external advice and support is sought as required. Infection control policies and procedures are reviewed annually.

Staff education occurs during orientation and is offered monthly throughout the year. Education sessions are open to all staff, residents and family/whānau if they wish to attend.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Infection control data is collated and analysed. Corrective actions are put in place should trended data show an increase in infections. Surveillance results are reported through all levels of the organisation, including governance.

## 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** | 2 | 45 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 3 | 95 | 0 | 3 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) was displayed throughout the facility and resident rooms. New residents and families are provided with copies of the Code as part of the admission process. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights |
| 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 | The staff demonstrated their ability to provide the information that residents need to have to be actively involved in their recovery, care, treatment, and support as well as for decision-making. Each of the younger people with a disability chooses a staff member that is their key worker. The key worker is matched to the needs of the resident. The key worker has regular contact as negotiated with the resident and supports and advocates for the resident, when this is required. There is demonstrated in documented evidence that the younger residents are actively engaged in decision making and their independence encouraged.  The residents' files reviewed had consent forms signed by the resident or by the enduring power of attorney (EPOA). The staff demonstrated their ability to provide information that residents required in order for the residents to be actively involved in their care and decision-making. The files contained copies of any advance care planning and the resident’s wishes for end of life care. Staff acknowledged the resident's right to make choices based on information presented to them. It was noted that some of the advance directives for resuscitation/not for resuscitation orders were signed by the family or general practitioner (GP), this was actioned at the time of audit to ensure that only the resident signs any advance directives. No further action is required. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Family/whanau reported that they were provided with information regarding access to advocacy services. Family/whānau were encouraged to involve themselves as advocates. Contact details for the Nationwide Health and Disability Advocacy Service was listed in the client information booklet, with the brochure available at the entrances to the service. In additional to the external advocacy service available, there are resident committee members and key workers who have advocacy roles within the organisation. Education is conducted as part of the in-service education programme. |
| 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 | There are no set visiting hours and family/whānau are encouraged to visit at any time. Family/whanau reported there are no restrictions to visiting hours. Residents were supported and encouraged to access community services with visitors, volunteers or as part of the life enhancement programme. The service has strong links with community organisations, schools and local groups in accessing services in the community, as well as incorporating community activities at Elizabeth Knox. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Complaints management is implemented to meet policy requirements. As confirmed during management, resident and family/whanau interviews, complaints management was explained during the admission process. Residents confirmed that the management’s open door policy makes it easy to discuss concerns at any time. The complaints register contains the dates, complaint, actions taken and outcomes.  Staff confirmed that they understood and implemented the complaints process for written and verbal complaints that occur. Complaints are a standing agenda item at the board and staff meetings.  The Ministry of Health had received a complaint for investigation by the Health and Disability Commissioner regarding the standard of care provided to a resident. The Deputy Commissioner has decided that no further action in relation to this complaint was required. It was evidenced at this onsite audit that actions were implemented to address any areas identified for improvement. The service has actioned improvements related to risk management, staff training and provision of care. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The family/whanau and residents reported that the Code was explained to them on admission and was part of the admission pack. Nationwide Health and Disability Advocacy Service information was part of the admission pack with brochures available. The service receives input from the local advocate. Each of the younger people at the service have a designated key worker, who also acts as an advocate. |
| 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 | Family/whanau reported that their relatives were treated in a manner that shows regard to the resident's dignity and independence. The residents' files indicated that residents received services that are responsive to their needs, values and beliefs. The care plans were based on the Eden Alternative philosophy of care. The family/whanau and residents reported high satisfaction with the way that the service meets the needs of the residents. Residents and family/whanau reported that residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect. One resident did comment that they had a concern regarding how a staff member interacted (in 2013) with another resident, and felt that it was appropriately addressed. This issue was sighted in and had been addressed in the complaints register. One resident reported that staff do knock, but do not always wait for permission to enter before coming into their room. The resident reported that this was acted on, and improvements have been implemented. |
| 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 were residents who identified as Maori at the time of audit. The chief executive officer (CEO) reported that there are no barriers to Maori accessing the service. As part of the Eden Alternative, specific cultural needs are identified and acted on. A resident who identified as Maori reported that their cultural needs are respected. Staff demonstrated a good understanding of services that are commensurate with the needs of the Maori resident and the importance of whanau. |
| 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 residents' files demonstrated resident’ goals and consultation with families (where appropriate) on the resident's individual values and beliefs. The residents and family/whanau reported they were consulted with care planning. The cultural needs of the residents are encompassed into the person centred care and are reflective of the Eden Alternative philosophy in meeting the resident’s needs. Staff demonstrated good knowledge on respecting each resident’s culture, values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff files reviewed had job descriptions and employment agreements with clear guidelines regarding professional boundaries. The family/whanau and residents reported they are happy with the care provided. The families expressed no concerns with breaches in professional boundaries and all reported high satisfaction with the care provided. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Evidence-based practice was observed, promoting and encouraging good practice. The service is a fully registered Eden Alternative home, which is reflective of the resident centred care at Elizabeth Knox. The policies and procedures are linked to evidence-based practice. The DHB care guidelines for aged care are utilised. The service has regular visits by the GPs, who are onsite for eight sessions a week. There are linkages with the local mental health services and palliative care services.  There is regular in-service education and staff accessed external education that is focused on aged care and best practice. The staff reported that they were ‘very satisfied’ with the relevance of the education provided. The family/whanau and residents expressed high satisfaction with the care delivered. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents reported they receive full and frank information and open disclosure from staff. The incident and accident reporting system recorded that residents and where appropriate, family are informed. There is a resident committee and key workers for the younger resident’s living with a disability, who act as advocates and voice any concerns. The residents and family/whanau reported that communication with staff and management is conducted in an open manner.  The service promotes an environment that optimises communication through the use of interpreter services as required. Staff education has been provided related to appropriate communication methods. The service has accessed interpreting services for the residents. Policies and procedures are in place to support this process. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | CI | The organisation ensures services are planned, coordinated, and appropriate to the needs of the younger (under 65) and older resident at rest home or hospital level of care. At the time of audit there were 123 hospital level of care, 22 rest home level of care and 27 residents under the age of 65.  Elizabeth Knox has a well-developed strategic plan with key goals linked to quality, service development, facility and site development and other core areas. There are amalgamated operational, quality and Eden Alternative plans that documented the organisation’s mission, vision and values. This action plan documents the goals, how the goals can be achieved and the timeframes for their implementation. The Trust Board members have a mix of clinical and business skills and sub committees link the management team with the Board members to monitor services and objectives and have responsibility for quality and risk management, investment and planning. The strategic planning incorporates the ‘Eden Alternative’ philosophy. Elizabeth Knox is the first fully registered Eden Alternative home in New Zealand.  The organisation is managed by a suitably qualified and experienced person with authority, accountability, and responsibility for the provision of services. The chief executive officer (CEO) is a registered nurse (RN) with a current practising certificate. The CEO has extensive background, experience and qualifications in nursing, social science and management. In the past 12 months the CEO has attended and conducted in excess of the contractual eight hours education in the management of aged care services. The chief executive is a trainer for the Eden Alternative, has attended and presented at conferences in aged care. The CEO has gained an international award for leadership in the ‘Eden Alternative’. The CEO is supported by the management team, clinical mentors and the quality and risk subcommittee. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | During a temporary absence a suitably qualified and/or experienced person performs the CEO’s role. The care director and accountant (who had a previous role as general manager of Elizabeth Knox) cover the role of the chief executive during temporary absences. The CEO reported they have full confidence in the care director to fill their role during temporary absences. For longer absences the service is reviewing the option of contracting a suitably qualified and experience person to undertake the CEO role. |
| 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 organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. Staff and residents confirm that they can input and understand the quality and risk management system. The service have a formalised evaluation and quality improvement system that is externally reviewed. The service also contributes to local, national and international benchmarking programmes.  The service develops and implements policies and procedures that are aligned with current good practice and service delivery and meet the requirements of legislation. The service is currently undertaking a major review of the policies, to ensure that the policies are current and are reflective of the organisation. The service is continuing to update policies according to their action plan. The policies are linked to the internal auditing processes to ensure that the policy reflects best practice and the requirements of the new electronic resident management system. There is a plan to review the care planning electronic records management provider and Elizabeth Knox have developed a plan to also review the clinical documentation to ensure they reflect the Eden Alternative. Effective systems are in place for identifying policies due for review and the updating of policies. The CEO confirms that staff received notification when policies are updated.  There is a document control system to manage the policies and procedures. This system sighted ensures that documents are approved by the board, available to staff and managed to preclude the use of obsolete documents. All documents are version controlled with staff having access to the current version of a document. As the service is still implementing their plan and transition to electronic records, a number of low risk documents have not been reviewed by their due date. There is a comprehensive review, updating and transition to electronic documents programme being implemented. The transition plan and CEO identified and report that the transition will be completed within the next six months. As it is evidenced that service is in the process of implementing this transition plan, no corrective action has been made.  Key components of service delivery are explicitly linked to the quality management system. The quality and risk management system is closely linked with the health and safety, complaints management and infection control programme for the service through the internal auditing process. The internal audit system reviews practices and the key components of the service delivery.  Quality improvement data is collected, analysed, and evaluated and the results communicated to staff and, where appropriate, residents and family/whanau. The organisation participates in an a number of national and international benchmarking programmes, relating to employee and resident/family satisfaction, clinical record audits, clinical care components such as pressure injuries, resident falls, restraint, medication errors and infections. A comprehensive internal audit programme is in place (sighted) and is appropriate to the scope and mission of the organisation. This includes audits related to clinical care, human resources management, health and safety, support services and infection control. There was limited documented review of the restraint minimisation practices (refer to the restraint standards). The internal audit results are reported at the two monthly quality and risk subcommittee meetings and to the board. The results of projects and internal audits are also fed back to staff and displayed on notice boards for resident and family/whanau to read.  A process to measure achievement against the quality and risk management plan has been implemented. There is a monthly health and safety meeting that includes the review of the quality and risk process related to health and safety, falls, pressure injuries and restraint use. Meetings include the review of key improvements, risks and hazards and looks at new ideas and solutions for improvements.  When indicated a corrective action plan addressing areas requiring improvement is developed and implemented. Corrective action planning was evidenced and well documented for projects. The internal auditing and opportunities for improvement forms sampled did not always include a documented corrective action plan on addressing these issues. The audit team were able to evidence that the areas identified for improvement have been implemented, though there was an inconsistent approach to documenting corrective action plans. The service also has a very responsive and informal approach to implementing corrective actions, which is not always captured in the documentation sighted.  Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau and visitors. The 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. A process that addresses/treats the risks associated with service provision is developed and implemented. The risk and hazard register sighted included the identified risks, how these are monitored, and the severity of the risk and if the implemented actions can isolate, eliminate or minimise the risk. The risks are reviewed two monthly at the board meetings.  Staff interviewed demonstrated understanding and involvement in the risk and quality management systems. The staff and residents have an opportunity to participate in the quality and risk management systems by completing improvement suggestion forms and feeding back to the area/hub representative prior to the health incorporated meetings. |
| 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 need to make essential notification to statutory and/or regulatory bodies is fully understood and complied with as identified in the reporting process undertaken related to infection outbreak management. The incident and accident forms used by the service identify who has been notified. The family/whanau members interviewed stated they are kept fully informed. There has been a staff injury that has been reported to the statutory body.  Adverse, unplanned or untoward events register and incident/accident forms were sighted for 2015. The register provides a comprehensive record of incidents and accidents, outcomes, severity level, actions, review and a description of the event. Staff stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required. The incident and accident register clearly documents the monthly reviews by the management team. The staff demonstrate good understanding of the adverse event reporting process.  A review of recent incident and accident reports identified a wide range of incidents are reported by staff and data is collected to identify trends. If an area for improvement is identified through the events reporting process and complaints or internal audits, this is addressed through corrective action planning and includes quality projects. As part of the falls management and pressure injury prevention programmes there is reflective practice to help improve understanding of what occurred in order to ensure improvements are implemented in the provision of care in the future. The reflective practice included the review an evaluation of falls and pressure injury prevention by the health and safety committee, benchmarking of results, review and evaluation by subcommittees of the board and the full board meeting. |
| 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 | Staff that require professional qualifications have them validated as part of the employment process and then annually. Professional qualifications are validated, including evidence of registration and scope of practice for service providers. The annual practising certificates (APC) for those staff that require them were sighted. The electronic time and attendance software system alerts management when the APCs are due. The records are maintained for contracted staff that require an APC (GPs, podiatrist, pharmacy).  Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. This includes police vetting, selection, interview and reference checking processes. The selection process includes the review of the application and those who meet the essential criteria are short listed, there are panel interviews which include a resident interviewing committee. The service has conducted individual and group interviews, which include a range of interactive activities. The organisation also has a recruitment process for volunteers.  Position descriptions, sighted for all roles, described staff responsibilities and best practice standards. The staff and volunteers completed an orientation programme with specific competencies for their roles which are repeated annually as confirmed during staff files reviewed. The orientation process also includes the service’s Eden Alternative philosophy.  Policy is implemented to ensure staff undertake training and education related to their appointed roles. There are specific ongoing education and competency programmes for the clinical mentors, senior care partners, care partners and volunteers. The education records, attendance sheets and education databases sighted cover all aspects of service provision to meet contractual requirements.  Resident and family/whanau members interviewed, along with the 2014 satisfaction survey results, identified that residents’ needs are met by the service. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | CI | Policy identifies staffing hours are rostered to meet residents’ needs and to comply with contractual requirements. Additional staff rostered to meet residents’ needs was observed on the days of audit. Required staffing levels and skill mix is clearly documented. A review of rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents’ needs. Residents interviewed stated all their needs have been met in a timely manner. The household staffing model, key workers for the younger people living with a disability and the input from volunteers exceeds the requirements of the DHB contract and is reflected in positive outcomes for the residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Resident information sighted on all documentation showed the resident’s name, date of birth and national health index number which allowed clear identification.  Information is securely stored and not accessible or on view to the public to ensure privacy is maintained. Information in resident files related to contact details for next of kin and other significant persons is checked at least annually during the multidisciplinary meeting.  The resident records, covering all areas of clinical care, are legible with the name and designation of the service provider clearly identifiable. Each resident has one clinical file which is written in by all health care members involved in their care, to assist with continuity of care.  Hospital resident files have daily entries made by the nursing staff and rest home level residents have much less frequent entries. Policy only requires staff to make a weekly entry for rest home level care residents. This was discussed with management at the time of audit and this practice was reviewed during the time of audit and a new directive has been sent to staff stating daily entries of clinical care will be made in all residents’ files. The service agreed this is reflective of current best practice and policy will be changed to show this requirement. |
| 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 | Entry criteria for each level of care offered (rest home, hospital, young people under 65 years old and interim care) is well documented and communicated to residents, family/whānau and referral agencies. The entry screening processes assist the service to meet residents’ requirements from the time of entry.  The entry screening meeting involves the prospective resident, family/whānau, and health professionals as appropriate. For example for residents under the age of 65 years a social working from the referral agency is involved.  Interviews with residents and family/whānau confirm the pre-entry meetings allowed them to identify all their needs and for the service to inform them how they would be met or if they could not be met. The principles of the Eden philosophy are discussed at part of the pre-entry meeting. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | When admission is required to the acute care hospital, the service utilises the DHBs transfer form and ‘yellow envelope’ approved system. The referral process documents any risks associated with each resident’s transition, exit, discharge, or transfer. This includes expressed concerns of the resident and family/whānau and a copy of any advance directives. With the transfer form/envelope, the service also provides a copy of any other relevant information, such as the medication chart. A file of a resident reviewed with a recent day admission to the acute care hospital evidenced that the transfer to and from the hospital was effectively managed. If a resident is transferred to another care facility a copy of the most recent assessment and care plan is also provided to the new facility. |
| 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. | PA Low | The medicine management system implemented by the service is documented in policies and procedures to reflect good practice and meet legislative requirements. The service used the robotic sachet pre-packed medication system at the time of audit. Medicines that are not pre-packed, such as liquids, are individually supplied for each resident. The stock medicines carried by the service are managed safely and according to current medication protocols. Pro re nata (PRN) medications are clearly documented and only used when required. The service also has standing orders which are under review and are awaiting all four GPs sign off. The standing orders currently being used do not meet all required guidelines for use in aged care.  All medicines are securely stored, correctly charted and administered by staff who hold current medication management competencies. Controlled drugs processes include cheeks by two nurses when administered, weekly checks by two staff and six monthly stocktake reconciliation. The medicine fridge temperature was monitored weekly, with the sighted temperatures within safe medicine storage guidelines.  The resident’s GP conducts medicine reconciliation on admission to the service and when the resident has any changes made by other specialists. The medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. Each medication chart is pharmacy generated and includes a picture of each oral medication for staff to easily identify all pre-packed medications. The pharmacy undertakes a six monthly reconciliation of all medication charts.  Not all medicine charts reviewed indicate if the GP had conducted a three monthly review and not all medicine chart signing sheets had staff specimen signature.  At the time of audit the service had no residents who self-administer medicines. The service has policies, procedures and self-administration guidelines to assess if a resident was competent to administer their own medicines. |
| 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 | The food service is contracted and the menu is reviewed and approved as being suitable for aged care annually. Regular dietitian reviews occur for individual residents as requested by the service. The food services are overseen by a chef with many years’ experience in the aged care industry. All staff who work in the kitchen are required to complete recognised NZQA qualifications in food services and food preparation.  The food services are monitored by the contracted service and by the services internal audit system. It is identified that the service is able to cater for all residents’ needs related to modified nutritional diets and any special likes and dislikes. This is confirmed by resident and family/whānau interviewed. There were no negative comments made during audit related to food. The service caters for all resident’s individual likes, dislikes and cultural needs as identified on the resident’s nutritional profile.  All aspects of food procurement, production, preparation, storage, delivery and disposal complies with current legislation and guidelines. Fridge and freezer recordings were undertaken daily and met requirements. Food is dated and labelled when decanted.  Each of the resident houses (wings) have small kitchen areas which allows residents and visitors to prepare and cook food if they choose. This is reflective of the principles of the Eden philosophy. On the days of audit one hospital level resident had a meat dish prepared in a house kitchen by a staff member and another resident under the age of 65 years had a special meal cooked for them by a family/whānau member. |
| 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 family/whānau is managed by the organisation, where appropriate. | FA | Service is only declined to a potential resident if the screening process identifies the service cannot meet the resident’s needs or the needs assessment identifies the resident requires a different level of care than that offered. The admission coordinator reports that if entry to the service was to be declined the referrer, potential resident and where appropriate their family/whānau would be informed of the reason for this and of other options or alternative services. The service documents the reason for declining an admission.  The admission agreement contains information on the termination of the agreement. It is identified that if the resident’s needs change and the service can no longer provide a safe level of care to meet the needs of the resident, they would be reassessed for the appropriate level of care. Residents requiring secure dementia level of care have been transferred to a facility that provides this service. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The service has commenced interRAI assessments. Staff training to undertake interRAI an assessment is an ongoing process. A mix of the electronic records and the service’s own assessment tools were in use at the time of audit. The assessment tools used by the service include falls risk, skin integrity/pressure area risk, continence, pain and nutritional assessment. All files reviewed had completed physiotherapy and occupational therapy assessments. The care plans sighted reflected the assessed needs of the residents from all service providers. The assessment processes sighted in the residents’ files covered the resident’s physical, psycho-social, cultural and spiritual needs. Where required, there are specialist assessments which also inform the care plan, such as a wound assessment or mental health assessment from DHB specialist services. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Residents’ files evidenced individualised care plans that reflected each resident's needs in a manner that is reflective of the Eden philosophy. The triggers from the interRAI assessment process and the paper assessments along with clinical and allied staff judgments are incorporated into the care planning. The residents’ files and care plans demonstrated service integration. All resident clinical information is contained in one file and everyone who has input into the resident’s care writes in the same folder. This includes medical information, nursing assessment, physiotherapy assessment and planning, occupational therapy assessment and activities plans, routine observations, therapies, family/whānau input, correspondence and specialist consultations. Information from all sources are shown on the resident’s plan of care to ensure care is integrated. Short term care plans are in place and linked through the handover reporting both written and verbally. Clinical staff interviewed demonstrated a high level of knowledge of what is required for each resident to meet their needs. They confirm there is very good communication among and between all services.  This is supported by resident and family/whānau members during interview. They report that staff have excellent knowledge and care skills. Two GPs interviewed expressed a high level of satisfaction with the care provided. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The provision of services and interventions are consistent with, and contribute to, meeting the residents' assessed needs and desired outcomes. The care plans reviewed were individualised and personalised to meet the needs of the residents. Resident input into the services they utilise is clearly documented and one example showed that a resident with a high risk skin integrity assessment should wear leg protectors. The resident refused and a compromise was reached. The resident is very happy with how this process was managed. The care was flexible and focused on promoting quality of life for the residents. All residents and family/whānau reported a high level of satisfaction with the care and service delivery. This is supported by the satisfaction survey results sighted. |
| 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. | FA | There is a weekly activities calendar located in each house and at the front desk, available to all residents and visitors. This identified planned activities which residents can attend if they choose to do so. Each resident has a social profile in their file which identifies their interests. From this information and in consultation with the resident and their family/whānau as appropriate, the service attempts to offer individualised activities many of which are undertaken by the very strong volunteer workforce. Examples sighted included knitting, bridge, book club and cooking. The occupational therapist reported that all activities are monitored and discussed with residents to ensure they add value to the residents’ daily living. Feedback on the activities programme is also sought through the weekly residents’ meetings. Programmes are modified depending on the resident’s needs and interests. The activities programme covers physical, social, recreational and emotional needs of the residents.  Many residents attend physiotherapy as an activity on a daily basis as an open invitation for all residents occurs each weekday morning. These sessions are very popular. The service has links with numerous community organisations, churches, local schools and child care centres and residents can attend onsite and offsite activities offered. The residents and family/whānau reported high satisfaction with the activities provided. With so much resident input into the activities they meet the needs of all acuity levels and age ranges. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Documented evaluations are resident-focused, indicate the degree of achievement or response to the support and/or interventions, and progress towards meeting the desired outcomes. Where progress is different from expected, changes to the care plan are shown.  The care plans sighted have changes made to match assessment findings and reflect the degree to which resident outcomes have been achieved. Care plans had been developed reviewed and evaluated at least six monthly.  Short term care plans were sighted in the files reviewed. When short term care plans are implemented to meet resident’s temporary needs they are discussed and included in the documented handover information.  The residents and family/whānau members interviewed reported a high level of satisfaction with the care provided at the service. |
| 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 | Residents are able to maintain their own GP if they wish to do so. At the time of audit, all residents use one of the four GPs who are contracted to work at the facility. A RN or GP arranged for any referral to specialist medical services and they undertake any required follow up. The resident’s files had appropriate referrals to other health and diagnostic services. Referrals sighted include consultation/visits with mental health services, general medicine and surgical services, specialist nursing services, optometrist and dental. Documentation identifies that residents are always given choices and their decisions are respected by the service.  The GPs reported that appropriate referrals to other health and disability services were well managed at the service. |
| 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, infectious or hazardous substances, generated during service delivery. | FA | Service providers follow documented processes for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. Policies provide guidelines for staff regarding the segregation, disposal, collection and recycling of waste and are developed in line with infection control requirements. Waste handling procedures include the management of incidents of accidents relating to waste and hazardous substances and current material data sheets for all chemicals were accessible. Emergency procedures and transporting waste procedures were also available.  Staff interviewed reported that there have been no incidents or accidents relating to waste of hazardous substances in the last 12 months. This was confirmed in collated adverse event reports sighted.  Waste and hazardous substances were safely stored. This included all chemicals. Sanitizers are installed in sluice rooms and sufficient supplies of personal protective equipment were available. Spill kits were also available.  Staff receive education on waste management, chemical safety and infection prevention and control; this has included blood and body fluid exposure. |
| 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 facility is divided into six main residential areas, over two levels. These areas are referred to as ‘house holds’ and includes one (newer) wing which was designed to incorporate the Eden Alternative. Refurbishment of resident rooms, bathrooms and staff areas throughout the older parts of the facility is on-going and the objectives for site developments are defined within the strategic plan.  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of all residents. All rooms are of sufficient proportions to accommodate equipment and aids. Corridors are wide and fitted with secure hand rails. External and internal ramps are safe and gently sloping. Residents have access to safe and accessible external areas.  The maintenance team conducts regular checks throughout the year, following a scheduled maintenance plan. Additional maintenance requirements are completed as they occur. Electrical equipment is tested as required. This includes equipment brought into the facility by the resident. Medical equipment is calibrated and records maintained. Hoists are regularly serviced by the maintenance team, following the manufacturer’s instructions.  The current building warrant of fitness was sighted. |
| 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 hygiene requirements. | FA | There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of residents. The facility has a combination of single or shared ensuite and communal facilities. All ensuite are designed for disability access and have adequate space for the resident, equipment and staff assistance. There are additional disability accessible toilets near the lounge and dining areas for residents to access. There are separate toilets and shower facilities designated for staff and visitor use.  Some of the toilets and bathing facilities in the older parts of the building are undergoing refurbishment. All facilities are maintained in line with infection control requirements. Hot water temperatures are monitored and ensure safety requirements are met. |
| 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 | There facility has a number of different room types and sizes. This includes five doubles rooms for those who would like a room to share. Although some of the bedrooms in the older areas are smaller is size, there is still room to safely accommodate furniture, personal items and equipment. All rooms sighted had been personalised by the resident, including accommodating the resident’s furniture and pets.  In interview, residents expressed satisfaction with their personal bed space. During the refurbishment, consideration has been given to ensure doorways into bedrooms and bathrooms are wide enough to accommodate equipment and mobility aids. |
| 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 is large, with a variety of different living, rest and lounge areas. These areas differ in size and function and each household has a lounge, dinning and kitchen area. Areas contain adequate furniture and seating arrangements, television sets, books, heating and access to external areas. These areas were observed to be well utilised by both residents and family members. This included the central corridor named ‘The Street’ which includes a café, hair dresser and a variety of seating areas.  Activities occur in areas which do not impinge on the privacy needs of residents who chose to not attend. There is also a separate physiotherapy room and occupational therapy area. |
| 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 | Cleaning services for the majority of the facility are provided by an external contractor. In interview, the contractor’s representative provided evidence that the required processes were implemented. This included staff training, provision of cleaning resources and on-going monitoring of the effectiveness of cleaning services. The cleaning team is onsite seven days a week and confirm they have access to cleaning resources and work schedules. Each area has a designated, and secure, cleaning room and cleaning trolley.  All laundry is completed on site. The central laundry is designed and maintained to meet infection control requirements. Industrial washing machines and dryers are pre-set to ensure infection control requirements are met and chemicals are dispensed through a closed system.  The newer household areas have smaller laundries for the residents who chose to do their own washing. Management has ensured that these areas are sufficient in size to accommodate residents with mobility aids. In this area residents are supported by ‘homemakers’ who help to ensure the area meets all cleaning and laundry requirements. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. An appropriate 'call system' is available to summon assistance when required. All bedrooms, ensuite and communal areas have access to the call system. The system can identify delays in answering bells.  Disaster plans are documented for a range of emergencies including outbreak management and pandemic planning. Adequate civil defence supplies are available and include the required equipment and stores. Alternative energy and utility sources are available in the event of the main supplies failing. This includes a recently installed generator, emergency lighting and water supplies. The central elevator and evacuations chairs can also be used in the event of a power shortage. Signage and flip charts for the management of emergencies are displayed throughout the facility.  Fire systems and emergency evacuation equipment is checked as required. A sprinkler system is in place. The building is separated by a number of fire cells. The notification of approval for the evacuation scheme was sighted and remains current. Fire drills are conducted every three months.  The organisation identifies and implements appropriate security arrangements. Access control alerts on the external doors indicate when the doors are opened. Security cameras are installed in external areas, the entrance access points and in the hallways. Security doors and intercom at the entrances are linked with the phone system.  Staff interviewed confirmed they received education in the management of emergencies. This is included during the orientation process, and thereafter in an on-going manner. There is also an adequate number of staff on each duty, each shift, with current first aid training. |
| 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 areas have plenty of natural light and safe ventilation. Residents living areas have a combination of windows and/or door opening onto garden areas. Temperature is controlled via a number of mechanisms and a variety of heating appliances are installed. This includes heat pumps, radiators, electric heaters, gas fires and solar panels for water heating. There is one designated smoking area for residents. This area is away from the residential areas. |
| 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 service provides an environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. The programme aims to establish, maintain and monitor procedures covering infection control practices. There are two infection control coordinators, one with a post graduate diploma in infection prevention and control, who leads infection control activities and reports directly to the board monthly. This is confirmed in meeting minutes sighed. However, all staff are required to take responsibility for infection reporting. This occurs on a specific form from all clinical areas.  During interview the infection control coordinators confirmed they have adequate and appropriate resources for the effective delivery of the documented infection control programme which is reviewed annually.  The programme includes actions taken to help keep residents, service providers and visitors safe by avoiding exposure to infectious diseases. Resident, family/whānau and staff confirm their understanding of these processes during interviews. |
| 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 team is led by two registered nurses with specific infection control qualifications and training. Their responsibilities are clearly shown in the infection control job description. The infection control team have access to persons with a range of expertise and skills, such as laboratory staff, GPs, an external infection control consultancy company, and the Ministry of Health.  Staff interviewed, including the infection control coordinators, confirm these are sufficient resources to implement the infection control programme. The infection control team includes a staff member from each house (wing) of the service and all disciplines are represented as confirmed in meeting minutes sighted. |
| 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 | Policies and procedure reflect current accepted good practice. They cover all aspects of infection control management, including the correct use of personal protective clothing/equipment. Cleaning and laundry procedures are located within the infection control information.  The infection control programmes annual review includes compliance with policies and procedures as evidenced during audit. Policies are appropriate to the services offered by the facility.  All staff interviewed verbalised their knowledge and understanding of standard precautions and stated they undertake actions according the IC policies and procedures as required. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff receive education related to infection prevention and control as part of their orientation and at least annually as part of the ongoing education programme offered by the service. An on-site infection control education is offered monthly and is open to all staff, residents, and volunteers and family/whānau if they wish to attend. This was verified by staff education records and confirmed by staff, resident and volunteer staff interviewed. Clinical staff also have access to on-line infection control education and access to specialist services if required. Both infection control coordinators attend an infection control specific conference annually to maintain their knowledge and skills.  All education sessions are evaluated to ensure participants understand what has been presented. Changes to the way infection control education is presented are made in response to evaluation feedback received. The infection control coordinators stated they use videos, basic terminology and make sessions interactive to keep the participants engaged. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control data collected is in line with what is required for a community facility as identified in the Health and Disability Services Standards. This is agreed to by the infection control team and the board.  Each infection is reported and data is collated, graphed, trended against previously collected data and reported to staff and at board level. This is confirmed in meeting minutes sighted. If an upward trend is identified then corrective actions are put in place and monitored by the infection control coordinators as appropriate.  There have been no outbreaks since the previous audit but staff interviewed confirmed their understanding of procedures should one occur. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint and enabler policies clearly defined the use of restraints and enablers, and how they differ. All enabler use was voluntary and in place to maintain the safety of the resident. In interview, staff were knowledgeable in the use, and definitions, of restraints and enablers. This was included in both the orientation programme and in-service education. Restraint team members reported that restraint was used as a last option, and only if it’s use had been assessed and approved. The assessment and approval process was confirmed in records sampled. On the day of the audit there were 62 residents with an enabler. A number of these were being used by the younger residents who had a physical disability. |
| Standard 2.2.1: Restraint approval and processes  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. | FA | The responsibilities for restraint processes, assessment and approval are defined. The role of the restraint coordinator is to monitor the use of restraint and report as required. The restraint team includes the coordinator, the physiotherapist and a team leader from each household. The restraint/enabler register confirmed that, on the day of the audit, there were 19 residents who had been approved to have a restraint in use at some time during the 24 hour period. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | There is a defined and implemented restraint assessment process. This includes the resident’s history and reason for restraint use. Restraint use was predominately implemented following a series of events. Explored alternatives and risks were discussed. Each restraint required the approval of the general practitioner, registered nurse, family member (or next of kin) and the resident (if able). The desired outcome was included. Restraint assessments sampled confirmed that restraint was used as a last resort and implemented to maintain the resident’s safety. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Once a restraint had been approved, it is fully recorded in the resident’s care plan. This includes the type of restraint, indications for use and monitoring requirements. There were two types of restraint. A ‘level one’ restraint required two hourly monitoring and a ‘level two’ restraint required one hourly monitoring. The difference between level one and two was reliant on the resident’s cognition, safety needs and response to the restraint. On the day of the audit there were no residents requiring a level two restraint.  Restraint records sampled confirmed that each episode of restraint was monitored as required. Adverse event reports confirmed that there had been no episodes of restraint use that had resulted in harm to the resident.  A restraint register is maintained for each household. This was updated as required and reviewed monthly by the restraint team. The register confirmed that restraint is used appropriately and that, for a number of residents, restraint use was minimised or discontinued after a period of time. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | PA Low | The restraint team meets monthly to review the use of restraint for each resident. The team works off the register and, it was reported, that the residents response to restraint and need for on-going restraint was discussed. However, records of restraint reviews are not fully documented. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | PA Low | There is some evidence that restraint is reported at a board level and mentioned at team meetings, however the requirements of a restraint monitoring and quality review have not been defined or implemented. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1  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. | PA Low | The service has documented medicine management systems which are implemented to allow safe and appropriate prescribing, dispensing, administration, review, storage and disposal of medicine. Staff demonstrate during audit safe administration practice. Whilst most documentation is completed a few minor exclusions were sighted. Standing orders are currently under review and the service is gaining sign off by all four GPs. | Four of the 28 medicine charts reviewed did not indicate if the GP had conducted a three monthly review. Eight of the medicine charts signing sheets had no staff specimen signature. Standing orders being used at the time of audit do not indicate contra-indications or who can administer the medications shown in the standing orders. A completed updated standing order form with all correct instructions was sighted but is awaiting sign off by all four GPs. | Ensure that the GP documents the three monthly reviews on the medication chart and that the newly developed standing orders are signed off. Staff who administer medicines must complete their specimen signature on each medication sheet.  180 days |
| Criterion 2.2.4.1  Each episode of restraint is evaluated in collaboration with the consumer and shall consider: (a) Future options to avoid the use of restraint; (b) Whether the consumer's service delivery plan (or crisis plan) was followed; (c) Any review or modification required to the consumer's service delivery plan (or crisis plan); (d) Whether the desired outcome was achieved; (e) Whether the restraint was the least restrictive option to achieve the desired outcome; (f) The duration of the restraint episode and whether this was for the least amount of time required; (g) The impact the restraint had on the consumer; (h) Whether appropriate advocacy/support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer; (j) Whether the service's policies and procedures were followed; (k) Any suggested changes or additions required to the restraint education for service providers. | PA Low | The restraint register was sampled. This provides the date of review meetings, any additions to the register, or any restraints which have been discontinued. Restraint team members interviewed reported that each resident is discussed in terms of on-going appropriateness of the restraint in use, any modifications, any risks or events, the resident’s response and monitoring. If a change in the restraint was required, this was recorded in the progress notes and updated in the care plan. However records of restraint review meeting are not maintained and the requirements of each review have not been defined. | There is insufficient evidence that monthly restraint review meetings include a full evaluation of all episodes of restraint. | Maintain sufficient evidence that monthly restraint review meetings include a full evaluation of each episode of restraint.  180 days |
| Criterion 2.2.5.1  Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education. | PA Low | Restraint policies do not define the requirements of restraint review and quality monitoring. There was some evidence that restraint use was reported at a board level and at quality and risk team meetings. However minutes did not include a review of restraint practice within the organisation. Restraint use is not included in the benchmarking programme and internal audits on restraint use have not been conducted as required. | Current systems do not include the process for, or implementation of, a regular quality review of restraint practice. | Define the process for conducting a quality review of restraint practice, and implement same.  180 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | CI | The service’s mission and values are linked to the Eden Alternative. Following the adoption of the Eden Alternative in 2009 and continual education and development process Elizabeth Knox has achieved full registration as an Eden Alternative Home in February 2014. The service has been through an external review process by ‘Eden in OZ & NZ’ to verify that they have achieved the full complement of the 10 Eden Alternative principles. The service has evidenced that they are achieving positive outcomes for the residents. It is documented that the service is achieving higher levels of spontaneity, increased outcomes in care and family engagement. Animals, plants and children are part of the everyday life. The wider community is increasingly involved in the daily life of the residents. Positive outcomes for resident’s satisfaction and safety have been measured. | The service’s commitment and the embedding of the Eden Alternative philosophy, which is integrated within the organisational vales; direction and goals, is rated beyond the full attainment. The service has gained recognition as the first fully registered Eden Alternative home in New Zealand. There is ongoing review of the Eden Alternative that includes a formalised process for analysis and actioning any areas for improvement in care, support and services for residents and their family/whanau. Positive outcomes for resident safety and satisfaction have been measured through national and international benchmarking and results of residents and relative satisfaction surveys. |
| Criterion 1.2.1.3  The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services. | CI | The chief executive officer (CEO) has received an international award for the organisation’s implementation of the Eden Alternative; the international award is recognition for their leadership in the Eden Alternative journey. This was the first time that the award had been issued to Australasia. The CEO facilitates public information sessions as well as hosting community groups, the DHB representatives and other aged care providers on the Eden Alternative. The board, staff and residents report high satisfaction, access and support and leadership from the CEO, which is impacting on positive outcomes for resident satisfaction. | The services achievement in ensuring the organisation is managed by a suitably qualified and experienced person is rated beyond the full attainment. The chief executive officer has gained international recognition for their leadership. There are formal processes in place for measuring the CEO achievement in key performance criteria. Residents and resident’s committee members reported high satisfaction with the ease of access to the CEO and input into implementing improvements throughout the service. |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | CI | There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. The staff levels are based on safe staffing levels for hospital level of care. The Household Model was initially implemented in Nikau House and has been rolled out to the other households at Elizabeth Knox. Each household comprises of approximately 15 residents, a clinical mentor (RN), and three care partners (health care assistants). Members of the wider Elizabeth Knox household support and health teams provide advice, services and assistance to promote the health and wellbeing of the residents (eg, GP, administration, occupational therapy, laundry, gardener, hairdresser, podiatrist, physiotherapist, life enhancer (activities/occupational therapist), homemaker, volunteers and maintenance). The service has clearly defined senior nursing roles and responsibilities. These include the care director, who oversees the life of the community and the delivery of the nursing services. The role of clinical mentor has been developed to provide expert nursing care to two or more of the households, manage the delivery of nursing to the households and coach the care partners and RNs. As part of the review, analysis and evaluation of the household model of care, the service has now employed an additional clinical mentor for the whole of the service, who provides additional support to the clinical mentors in each of the households. The household model was reviewed and improvements made for the roll out to all the households at Elizabeth Knox.  In addition to the household staffing, there is an organisation wide care educator to identify the training needs of the care team and delivery group and one to one education and training. There are also additional homemakers (cleaner/domestic worker) and a life enhancer (diversional therapist) for each floor. The service has three physiotherapist and four physio assistants, an occupational therapist and three OT assistants to assist in meeting resident’s needs.  There are approximately 850 volunteers who provide support to the staff and residents at Elizabeth Knox. Elizabeth Knox has two volunteer coordinators who provide support seven days a week. The volunteers have formalised selection, recruitment and ongoing education processes. There are staff support, companionship and elder support roles that the volunteers are selected and trained for. The training for the volunteers includes health and safety, orientation to the Eden Alternative and communication with residents. The volunteers can also access the staff ongoing education programme. The volunteer programme has gained national recognition and has gained a diversity award in 2014 for Elizabeth Knox’s dedication ‘to changing the face of residential care’ with the multicultural volunteers and staff that promote companionship and one to one communication which includes 47 different nationalities and languages. The volunteer coordinator has conducted case studies into the benefits of the volunteers and positive outcomes for resident’s satisfaction and safety. The availability for the volunteers to provide support and companionship to residents is also linked to reducing the number of falls. | Achievement beyond the expected full attainment is evidenced for the services process for staffing and volunteers to ensure the needs of the residents are being met. A review process has occurred for the household model of staffing and input from volunteers, which has included analysis and reporting of findings. There is evidence of action taken based on findings and improvement to service provision. Throughout the review processes and satisfaction surveys from residents and relatives positive outcomes in resident satisfaction has been measured. |

End of the report.