

Knox Home Trust Board

Introduction

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

The audit has been conducted by 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](#).

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: 14 November 2016 End date: 15 November 2016
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:	185

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Elizabeth Knox Home and Hospital provides rest home and hospital level care for up to 191 residents, including younger people with a physical disability. The service is operated by the Knox Home Trust Board and managed by a chief executive who is supported by a care director, three other executive team members and seven clinical mentors. The service has fully implemented the Eden Alternative, being internationally recognised for their work in this model of care. The Eden Alternative model of care seeks to eliminate the three plagues of loneliness, helplessness and boredom for elders through person-directed care. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the required Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, and one of the four general practitioners who work with the residents.

This audit has resulted in a continuous improvement rating in the area of governance, strategic and operational planning and identified areas requiring improvements relating to policies and procedures, timely completion of 'interRAI' assessments and reviews, integration of the paper based and electronic care planning tools, evaluation and updating of long term care plans and some aspects of medicine management. Improvements to the management of restraint have resolved two of the three areas identified as requiring improvement at the previous audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services for the multicultural group of residents.

The quality and development coordinator is responsible for the management of complaints. A complaints register is maintained and demonstrates that complaints have been resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The recently reviewed and updated strategic plan sets the goals and direction for the service, operational plan and quality plans, with the Eden Alternative philosophy incorporated throughout. Systems are in place for monitoring the services provided, including regular reporting to the governing body.

The facility is managed by an experienced and suitably qualified chief executive, recognised internationally for her leadership with the Eden Alternative approach. A quality and risk management system includes regular audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction. Collection, collation and

analysis of quality improvement data, including benchmarking data, is occurring and is reported to the board (including the quality and risk sub-committee), and staff meetings, with discussion of trends and follow up where necessary. Adverse events are documented electronically and seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and health and safety hazards identified.

The human resource management policies are based on current good practice and guide the system for recruitment and appointment of staff. A comprehensive orientation and staff training programme ensures staff are competent to undertake their role. A systematic approach to identify, plan, facilitate and record ongoing training supports safe service delivery, and includes individual performance review.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. The rosters support a staffing model based around providing a small multidisciplinary team within each of the household/home areas in the facility, thus promoting continuity of care for the resident group.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The needs of new residents are assessed by members of the multidisciplinary team on admission and within the required contractual timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care partners and employed allied health staff (physiotherapists and occupational therapists) and the general practitioner team. Volunteers play and

integral support role in the facility. On call arrangements for support from senior staff are in place. Verbal and written shift handovers assist communication between staff of resident care needs.

Care plans are developed, are individualised and based on a comprehensive and integrated range of clinical information. Short term care plans are a means to manage any new problems that might arise. All residents' files reviewed demonstrate that needs, goals and outcomes are identified, personalised and reviewed. Residents and families interviewed reported being well informed and involved in care planning, decision making and evaluation, and that the care provided is of a high standard. Quality of life and engagement of residents is an organisational priority, with a wide range of activities, community participation and involvement of children, pets and the wider community apparent in resident's day to day life.

Meaningful activities are based around the resident's preferences and the ten Eden Alternative principles which seek to empower residents and improve their well-being with support from their care partners and the allied health care team. A wide range of activities in the home and local community aims to eliminate loneliness, helplessness, and boredom. Residents actively participate in decision making about the priorities in their homes. Pets play a significant part in day to day life.

Medicines are managed according to policies and procedures based on current good practice and are consistently implemented using a manual system. Medications are administered by registered nurses and care partners, all of whom have been assessed as competent to do so.

The food service is delivered from a new purpose built kitchen facility. The menu meets the nutritional needs of the residents, with special needs catered for. Policies guide food service delivery, which is implemented by staff with formal qualifications. The kitchen was well organised, clean and meets food safety standards. Residents interviewed verified their satisfaction with the new menu and meal variety.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness. Refurbishment of resident areas and rebuild of the kitchen area has not required any changes to the New Zealand Fire Service approved evacuation plan.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff were aware of the contents of organisational policies and procedures on restraint minimisation and safe practice, which cover all aspects of the standard. The restraint coordinator has established systems that ensure monitoring and documentation in relation to restraint and enabler use is consistent with requirements. Restraint use is being evaluated at both individual and organisational level with reports going through to the quality management system and data contributing to the benchmarking process.

Infection prevention and control

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

Standards applicable to this service fully attained.

Aged care specific infection surveillance is undertaken, with an increase in the range of infections being monitored in 2016 and is appropriate to the resident groups. Results are analysed, trended, externally benchmarked and reported through all levels of the organisation. Follow-up action is taken as and when required. Review of a recent outbreak event has resulted in identification of learning opportunities and implementation of practice improvements. An external appointment is underway to strengthen infection prevention and control in the service.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	15	0	3	1	0	0
Criteria	1	40	0	1	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and procedure supports the principles of the Code, encouraging any issues to be resolved as close as possible to the 'point of care'. Information on the complaints process is provided to residents on admission and there is complaints information and forms available in the facility. Complaints reviewed had been made verbally, through use of email to the chief executive and by letter.</p> <p>The complaints register reviewed showed that 25 complaints have been received to date over the past year and that actions taken are documented and completed within the timeframes specified in the Code. A sample of 10 complaints were reviewed in detail. Nine of the ten complaints reviewed had all necessary details recorded and the complainant was happy with the outcome. The one case where details were incomplete was followed up on site by the quality and development coordinator. This was not a systemic issue. Residents interviewed reported that issues were dealt with early, thus avoiding the need for a complaint to be made. Where possible, improvements have been made as a result.</p> <p>The quality and development coordinator oversees complaints management with reporting to the chief executive and board noted. Staff interviewed confirmed an understanding of the complaint process and this is included in the orientation and training timetables.</p>
Standard 1.1.9:	FA	Residents and family members stated they were kept well informed about any changes to their/their relative's status,

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed and in the electronic system. There was also evidence of resident/family input into the care planning process. Elizabeth Knox is strongly committed to the Eden Alternative philosophy of care which supports empowerment of residents and their involvement in all aspects of their care and decision making. Residents spoke of 'transparency' in relation to communication. They stated there is an Eden Alternative meeting once a week, plus a residents' meeting once a week (minutes sighted) and these provided opportunities to express grievances to the chief executive (CE). They noted there is always a senior staff person around to talk with and they will 'come up to us and update us on anything we have told them is worrying us'. The younger people, in particular, talked of the value of volunteers in getting concerns sorted on residents' behalf (in an informal advocacy role).</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services are accessed via the Auckland District Health Board if necessary, although this is rarely required as there is a multicultural workforce and a list of staff available and languages spoken that can be used, as appropriate. Family members are also available to provide support, where this is appropriate.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>CI</p>	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The chief executive (CE) described the recent process around the development of the strategic plan (2016 – 2020) and the ongoing development related to the Eden Alternative purpose, values, direction and goals, which meet the requirements for continuous improvement.</p> <p>The documents reviewed describes annual and longer term objectives and the associated operational plans. The CE provides a monthly report against the objectives to the board of directors. A sample of reports reviewed showed adequate information to monitor performance is reported including financial performance, risks and issues and progress.</p> <p>The service is managed by a CE who holds relevant qualifications and has been in the role for eight years. She has the necessary skills and experience and is recognised nationally and internationally as a leader in the Eden Alternative. The CE confirms knowledge of the sector, regulatory and reporting requirements and maintains currency in the sector through membership of the NZ Institute of Directors, the NZ Aged Care Association and attendance at relevant national and international conferences and forums, some as a speaker.</p> <p>The service holds contracts with the ADHB and Ministry of Health for younger people with a physical disability (YPD), respite care, long term hospital and rest home care and palliative care. At the time of audit 26 residents were receiving YPD care, 36 rest home level care and 120 hospital level care.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The organisation has a quality and risk system that reflects the principles of continuous improvement and the Eden Alternative and is understood by staff. This framework has recently been reviewed to better align with the Eden Alternative. The quality plan includes management of incidents and complaints, audit activities, satisfaction surveys, benchmarking with an Australasian organisation, clinical incidents managements and being part of an International accreditation programme.</p> <p>Meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs and related information is reported and discussed at all levels in the organisation, including the board of directors. The recently expanded quality and risk sub-committee of the board supports the quality initiatives. This key forum now includes three board members, one GP, the commercial manager and the CE. Minutes reviewed include discussion on pressure injuries, restraints, falls, complaints, incidents/events, infections, audit results, and health and safety risks. Staff reported their involvement in quality and risk activities through audit activities and discussions at meetings as well as education and quality improvement initiatives as a result of the Eden Alternative. Relevant corrective actions are developed and implemented as necessary and demonstrated continuous improvement is occurring. A negative infection control trend led to an external audit and a project put in place to reduce infections. The project included staff from the laundry, homemakers (cleaning staff) and care partners and included additional Careerforce education. The annual resident, family and staff satisfaction surveys demonstrate a high level of satisfaction. Results from the resident and family satisfaction surveys have been fed back to residents and families and reported in the monthly newsletter along with comments on the areas where suggestions for improvements have been made. Residents are involved with quality activities (eg, the 'Food for Thought' group played a key role in the recent kitchen and food services development).</p> <p>The system for document control and ensuring policies and procedures are current is under review with a change to an electronic system in progress. At the time of audit there are a large number of policies out of date and the system does not support adequate document control.</p> <p>The quality and development coordinator described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The risk register shows regular review and updating of risks, risk plans and the addition of new risks. The coordinator is aware of the Health and Safety at Work Act (2015) requirements and the board of directors have been updated on changes, expectations and responsibilities.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p>	<p>FA</p>	<p>Staff document adverse and near miss events on either an accident/incident form or in to the electronic system. If on a paper form, these are then entered in the electronic system by the clinical mentor (RN). A sample of incidents forms reviewed show incidents are investigated, action plans developed as necessary and actions are followed-up in a timely manner. Adverse event data is collated, analysed and reported to staff meetings and the quality and risk meetings. Minutes reviewed show discussion in relation to trends, action plans and improvements made.</p>

<p>untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>Benchmarking data reviewed related to falls, pressure injuries and use of restraint shows a downward trend.</p> <p>Policy and procedures describe essential notification reporting requirements (eg, pressure injuries, health and safety). The quality and development coordinator discussed several examples of reporting since the previous audit, including a death to the coroner in 2015. Documentation from the coroner was reviewed. This has been closed by the coroner with no actions required by Elizabeth Knox (March 2016). There has been a recent change in board membership and confirmation of reporting to the Ministry of Health and the Waitemata DHB was confirmed by the CE to the lead auditor.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current, reflect the Eden Alternative and define the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. Residents form part of the interviewing team when selecting a clinical partner staff member. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained and well organised. APCs for the four contracted general practitioners (GPs), occupational therapists and physiotherapists were sighted as well as the necessary documentation for the podiatrist.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the initial three-day orientation, followed by the staged three-month process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis. Mandatory training requirements are defined and scheduled to occur over the course of the year. Care partners have either completed or commenced a New Zealand Qualification Authority education programme through Health Ed Trust, with the aim of having 80% of care partners completing the Health and Wellbeing Certificate under Careerforce. A staff member is the internal assessor for the programme. Remuneration is linked to training. Education records reviewed demonstrated completion of the required training, plus completion of a wide range of additional training and attendance at conferences and courses. Five staff have completed an eight-day leadership course, with a second group of five about to commence this programme. Twenty-one staff, including care partners, are attending a 'Dementia beyond drugs' programme. Staff reported that they feel well supported by the organisation and that their professional development goals are identified as part of the annual performance appraisal process. The performance appraisal process has recently been updated to better align with the Eden Alternative and to simplify the process. At the time of audit are 20 of the 180 staff overdue for a performance appraisal, however five of these people are on parental leave. There is a plan in place to complete the 15 other staff members</p> <p>Elizabeth Knox utilises a large group of volunteers (around 800). One of the two volunteer coordinators interviewed</p>

		discussed selection, screening, orientation and training requirements. These meet current good practice.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery. This has been recently updated following an extensive review to better align staffing with the Eden Alternative, ensuring a smaller work team provides care to each 'household'/home. This aims to ensure continuity of care for each group of residents. Each home's roster has a suitable skill mix and mix of roles and staff with varying levels of experience. RNs have developed special areas of interest to support the development of specialist skills (eg, palliative care). The facility adjusts staffing levels to meet the changing needs of residents and examples of providing one-to-one care, if necessary, were discussed.</p> <p>A permanent group of staff cover the night shifts which includes three RNs and eight care partners. The organisation has recently employed an extra four staff members to establish their own internal bureau. This will be a staged implementation. In addition, improvements have been made to how any external bureau staff are used with the CE providing education to bureau staff about the Eden Alternative. Some additional shifts and part shifts have been added in those homes where the workload has increased due to increasing needs of the resident group. In addition to care partners and senior care partners, there are laundry staff, homemakers (cleaners), a team of physiotherapists and occupational therapists, clinical mentors, 'life enhancers' and a care director. The nurse educator also supports staff.</p> <p>Care partners reported adequate staff were available and that they were able to complete the work allocated to them. Residents and families interviewed reported that staff are busy but their needs are met and they are very satisfied with the services provided at Elizabeth Knox. Observations and review of a four-week roster cycle sample during this audit confirmed adequate staff cover has been provided. There is 24 hour/seven days a week RN coverage to support all types and levels of care.</p> <p>Volunteers are used appropriately as part of the Eden Alternative, providing companionship and support with activities, both in the community and in the facility.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative</p>	PA Low	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. Standing orders have been updated in November 2015, are current and comply with guidelines.</p> <p>A safe system for medicine management was observed on the day of audit. The organisation uses a unit dose packaging system and associated documentation is provided by the contracted pharmacy. The staff observed in medicine administration activities demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of the process. All staff who administer medicines are assessed as competent to perform the function they manage.</p>

<p>requirements and safe practice guidelines.</p>		<p>Medications are supplied and checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked and recorded by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries. Pharmacist input is provided to undertake quantity stock checks. Medicines are stored in accordance with manufacturer's instructions in dedicated medication areas in each home.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines. Not all requirements for pro re nata (PRN) medicines are met (see 1.3.12.1). The required three monthly GP review is consistently recorded on the medicine charts sighted.</p> <p>Residents can self-administer medications. The process for one resident was reviewed and demonstrates that appropriate processes are in place to ensure this is managed safely and regularly reviewed.</p> <p>Any medication errors are recorded on an accident/incident form and reported in the electronic system for each resident where applicable. The resident and/or their designated representative are advised should an error occur. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified. Medication competency is regularly reviewed as part of the staff education programme.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by an external contractor using two qualified chefs and a kitchen team. The menu is in line with recognised nutritional guidelines for older people. It follows summer and winter patterns and offers a range of menu options to meet preferences and specific dietary requirements. The menu has been reviewed and commended by a qualified dietitian in April 2016. The small number of recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the food safety plan. The food services manager holds a chef qualification and attends relevant education e.g. the use of food moulds for texture modified diets. Kitchen staff are trained in safe food handling.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. This information is readily available to kitchen staff and care partners serving meals from the hot boxes sent to each home. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of improved resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. Meal times are somewhat</p>

		flexible to meet the individual circumstances, activities and preferences in each home.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information (including from interRAI) is documented into an initial and long term plan of care. Validated nursing assessment tools such as pain scale, falls risk, continence, skin integrity, nutritional screening and Mini Mental Scale (MME) scale are used as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information including a social history. Not all residents have current interRAI assessments completed by the trained InterRAI assessors on site (see comments 1.3.3). It is reported that there has been a net loss of trained assessors in the organisation in spite of training additional assessors in recent months. There is a documented system to track due dates for these assessments. Physiotherapists assess resident's mobility and function, plan care and monitor progress. Assessment processes detail the resident's physical, psycho-social, cultural and spiritual needs. Wound and additional specialist assessment or mental health assessment from DHB specialist services are requested appropriately and undertaken when required.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Review of 15 resident files reflects the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidence service integration with progress notes, medical and allied health professional's notations clearly written, signed and dated, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff such as at shift handover. Residents and families reported participation in the development and ongoing evaluation of care plans. A family meeting is the forum to plan and review care each year. Records of this are maintained</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs in accordance with the Eden Alternative philosophy was evident in all areas of service provision.</p> <p>The GP who was interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and care is delivered in a timely manner. Medical advice is appropriately sought. Care partners confirm that they provide care as outlined in the documented care plan and as requested by the registered nurse. A suitable range of equipment and resources is available, suited to the level of care provided and in accordance with the residents' needs. Interview with residents and families confirm that staff have appropriate skills and knowledge for the roles they perform.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Assessments are regularly reviewed to help formulate an activities programme that is meaningful to each resident. The resident's activity needs are re-evaluated as part of the formal six monthly care plan review.</p> <p>A calendar of weekly activities is available in each 'home' to all residents and visitors. This offers a range of planned activities which residents may choose to attend. Individualised activities and small group activities are supported by a volunteer team who are actively engaged with residents on a day to day basis over a seven-day period. The range of activities included is extensive and options are reviewed with residents on a regular basis to ensure they continue to meet their needs and add value and quality of life. Physiotherapy forms a major part of the programme, with a focus on maintaining mobility and dexterity. Strength and balance are promoted through a morning "drop in" to the gym, or individual sessions with the resident in their 'home' according to their individually developed programme. Approximately 60 people attend the open sessions in the mornings and 15 – 20 have individual sessions in the afternoons.</p> <p>Elizabeth Knox Home and Hospital has links with numerous community organisations, churches, local schools and child care centres and residents can attend onsite and offsite activities offered. Visiting performing groups were in attendance on the days of audit. Pets play a large part in the daily life of the residents, with several dogs, cats and chickens integrated into the community as part of the commitment to the Eden Alternative.</p> <p>Residents interviewed confirmed they find the programme enjoyable and personalised to their needs. Residents also meet regularly for a resident meeting, where activities and interests are discussed and planned for. Resident and family satisfaction surveys indicate a high level of satisfaction with the programme and that information is used to improve the range of activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN or the Clinical Mentor using the written "stop and watch" system.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN (see comments 1.3.3). Where progress is different from expected, the service usually responds by initiating a short term plan of care. The short term plans sighted have usually been reviewed and progress evaluated as clinically indicated (daily, weekly or fortnightly for up to six weeks). Other plans, such as wound management plans are being evaluated each time the dressing is changed or at least weekly. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes to the support provided.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The current building warrant of fitness is current (expiry date is 28 September 2017). There has been a refurbishment programme of the older resident areas but this had not changed the foot print of the building or the evacuation scheme requirements. (These were updated and approved after the recent building extension in July 2014). The kitchen rebuild has recently been completed and is functioning under the current building code requirements. A code compliance certificate is in the process of being issued. A certificate of public use is not required for this area, nor any changes to the current evacuation plan.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Elizabeth Knox Home and Hospital is presently recruiting for an infection control coordinator to assist in the oversight of the Infection Prevention and Control programme (IPC) for eight hours per week. This is part of the wider revision of the IPC programme, which will also include the development of 'resource staff' in each home.</p> <p>Surveillance is appropriate as recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. The range of surveillance has increased in 2016, to cover a wider range of relevant items. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. The organisation also contributes data to the QPS benchmarking programme. This indicates reported infections are close to the mean for the benchmarking group.</p> <p>When an infection is identified, a record of this is documented in the electronic resident management system and clinical record. The infection control coordinator closes out reports where an infection has been treated with a course of antibiotics. Monthly surveillance data is collated, reported per 1000 occupied bed days and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and meeting minutes. Graphs are available to identify the benchmarked results for previous quarters, and comparisons against previous years. Results are reported to the quality meetings and a summary reported to the Board. Benchmarking has provided assurance that infection rates in the facility are below average for the sector for respiratory infections, with close monitoring of any results which are above the mean in the sector.</p> <p>New infections and any required management plans are discussed at handover, to ensure early intervention occurs. Examples of this were noted during the audit.</p> <p>A summary report for a recent gastrointestinal infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up had been implemented. Learnings from the event have been identified and incorporated into practice, with additional staff education implemented.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The definition of enablers in organisational policy and procedure documentation notes that their use is voluntary. Staff confirmed during interview that they were aware of the requirements around their use and written consent forms in client files demonstrated they are being used according to documented protocols. A range of enablers including lap belts, chest harnesses and foot straps are in use, however, there was no evidence of enablers being used for reasons other than for the safety of the residents.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Records in the personal files of residents who use restraints include completed restraint monitoring forms. Staff have received ongoing education on the monitoring processes in response to some previously identified deficits in the internal audits on restraint use. Individual reviews of restraint use are being completed at the residents' usual six monthly review time, or earlier when indicated. The clinical mentor from each house reviews the use of enablers and restraints once a month and reports to the restraint coordinator and subsequently the restraint review committee about the need for ongoing use of restraints and enablers. There is documented and reported evidence that the considerations in (a) to (k) of this standard, as relevant for individuals, are covered during these reviews. Changes to restraint use are made as indicated and two examples were provided. The corrective action raised at the last audit has been satisfactorily addressed.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Restraint is a component of the quality management system. Reviews of restraint use are being undertaken by the restraint review committee meeting on the third Wednesday of each month and the restraint co-ordinator has undertaken three monthly internal audits on restraint. These cover restraint related assessment processes, clinical documentation, consent and care plans as well as staff knowledge and training, policies and procedures and the identification and reporting of data and trends. The restraint coordinator pro-actively pursues any gaps.</p> <p>Quarterly reviews of restraint data has been presented for the quality management system and contributes to the benchmarking programme with 98 other facilities. The data is currently demonstrating that restraint use is trending down by 15.72% and is below the mean. Issues raised for corrective action at the previous audit are no longer evident. The previous corrective action request is now addressed.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by</p>	<p>PA</p> <p>Moderate</p>	<p>Policies, procedures, work instruction and forms are available in both hard copy versions and electronically. Work is in progress to consolidate and update the around 600 documents on the electronic data base. The current electronic document control system, discussed and reviewed with the quality and development coordinator, shows that many of the policies/documents are overdue for review; however, the number overdue for review was not easily established and was unknown. The coordinator reports this is around 50% of the 600 documents. In the one resident home where policies were discussed and reviewed, the paper version of the clinical policy manual had no policies that were current; some being at least 10 years overdue for review, many of these now being obsolete. There was both an Elizabeth Knox infection control policy manual and an externally supplied infection control manual available, with staff assuming the externally supplied manual was the one to refer to.</p> <p>Examples seen of recently updated policies (eg, restraint minimisation and safe practice, medication standing orders) demonstrate that these have</p>	<p>At the time of audit there are around 50% of the approximate 600 policies and other documents overdue for review in the electronic data base. There are also paper version of policies available for use in the clinical areas that are overdue for review and/or are redundant.</p>	<p>The service establishes the exact number of overdue policies and procedures and implements a process to ensure these are reviewed at regular intervals, aligned with current good practice and</p>

policy.		<p>been developed based on current good practice and referenced to appropriate sources. Board/governance policies have been reviewed, are in draft and awaiting sign off at the next board meeting.</p> <p>The policy related to policy development and review is also out of date and does not provide the necessary guidance to support the future planned developments (eg, review of policy timeframes, referencing, cross referencing to other policies, document control and authorisation details). An educator is available to support staff with the introduction of new policies.</p> <p>The CE, the day following the audit, reports that all paper version of policies have been removed from clinical areas and that the electronic version is the only version to be used by staff and that a stock take is in progress to assess the extent of overdue policies and develop a plan to address this.</p>		<p>document controlled.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	<p>The standing orders document has recently been updated (November 2015) and signed off by the four general practitioners. Specimen signatures are included in the medication records in the 26 files sampled at audit. Both actions address the previous corrective action requests.</p> <p>There are examples of pro re nata (PRN) medicines prescribing which does not include the indications for use (eg, this is noted for paracetamol, Mylanta and metoclopramide prescriptions). Staff state that they are always used for the same purpose and this is confirmed by the general practitioner.</p>	Pro re nata medications do not consistently state the indications for use for three commonly used medicines.	<p>Ensure prescribing for pro re nata medicines (PRN) includes the indications for use.</p> <p>180 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is</p>	PA Moderate	The organisation has implemented an electronic system for care planning documentation in addition to the hard copy records. The information	InterRAI assessments are not always	Undertake further

<p>coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>		<p>collected and recorded includes nursing assessments, InterRAI, VCare short and long term care plans, observations and medical, allied health and nursing progress notes. The long-term care plan is completed electronically, updated six monthly and printed from the electronic record for the hard copy file.</p> <p>In six of fifteen residents' files reviewed across the service, the system is not fully implemented in that there is conflicting or incomplete information between the records. This relates to care needs, inadequate integration of newly identified problems into the plan and incomplete evaluation and/or close out of short term problems in a timely manner. Updates have not consistently been printed for inclusion in the hard copy file, resulting in out of date or incomplete information between the two records.</p> <p>Infection control alerts (eg, for MRSA and ESBL) are consistently included in the electronic record and alerted on the outside of the hard copy file. These alerts are not seen to result in the development of a plan of care to guide staff on the management of the problem.</p> <p>Records sighted on the day of audit indicate that 30% of interRAI assessments are not completed or reviewed within the contractual timeframes. The service reports that ARC contractual obligations are not achievable due to a factors such as protracted delays (up to 2 weeks) in release of the assessment from other providers, delays in training of RNs. Timeliness issues have been logged with InterRAI.</p> <p>In the clinical records reviewed (hard and soft copy) the interRAI Long Term Care Facilities Assessment Tool is not fully utilised to assess residents' needs and inform residents' care plans. Newly identified problems are not consistently resulting in the development of a suitable plan (short or long term). Examples in three resident files included a change in behaviour, mood, and a newly identified infection. Evaluations and close out were not completed in two of four short term plans sampled. EKHH stated that the deficit based approach of InterRAI does not support the organisation approach to strengths based care planning and is only one source of information for planning care. They state that some of the triggered CAPS do not match other sources of assessment or the teams experience of resident needs.</p>	<p>completed and/or reviewed in the required time frames. New deficits identified at reassessment have not been consistently incorporated into the long-term care plans. Coordination of care is not ensured, with discrepancies in information between the electronic and hard copy systems in use.</p> <p>Specific plans in relation to residents with a known infection such as MRSA and ESBL are not included in the plans reviewed where alerts about infections are included on the file.</p>	<p>development of the care planning system to ensure care planning information is complete with effective linkages maintained between all elements of the electronic and manual systems.</p> <p>Implement processes which ensure all interRAI assessments and evaluation of residents' needs is completed within the contractual timeframes.</p> <p>90 days</p>
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<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Moderate</p>	<p>Although short term care plans are being developed when new problems arise, this does not always occur appropriately. There are also examples where changes in the resident's condition or health status is not captured and transferred to the electronic LTCP for printing for the hard copy file in a timely manner. These plans and evaluations are subsequently printed for use in the hard copy file to guide care, but the most up to date version is not always available to care partners as evidence in several files. Examples include a change in the resident's infection status, reference to initiation of a last days of life plan and a variety of plans used to manage short term or new problems. Progress notes are used to update care status. The senior team report that the hard copy record is regarded as the one used to direct care delivery.</p>	<p>Updating of the care plan is not always evident when the resident's condition changes, nor the current plan made available to care partners in its most current version to guide residents' care.</p>	<p>Initiate a process which ensures that where resident progress is different from expected, the service makes necessary changes and makes available the most current plan of care.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>Elizabeth Knox is a nationally and internationally recognised leader in the work of the Eden Alternative philosophy of care for older people. The strategic and operational planning process has increasingly formed the basis of the values, direction and goals of the organisation since its first inception in 2009. All aspects of the service are integrated into this model with ongoing developments over the past 18 months to job descriptions, the performance appraisal process, staff development, the building designs and layout of the smaller ‘homes’ within the complex, resident involvement in the service, volunteer programmes and the ‘Inclusion Programme’, whereby residents are involved (re-engaging) in contributing by themselves volunteering in the community. The ongoing direction, leadership and commitment from the board of directors and the CE are evident in the recent strategic planning process. Measurable outcomes and positive trends are noted against the Eden Alternative direction and goals and demonstrate a sustained and continuing improvement in falls reduction, pressure and skin injuries, use of restraint, resident and family satisfaction and occupancy rates.</p>	<p>The ongoing commitment by the board of directors, the CE and the staff at Elizabeth Knox to the Eden Alternative and improving outcomes for the residents and their families is reflected through the strategic, operational and quality planning process. The purpose, values, direction and goals reflect this philosophy and has resulted in sustained improvements to clinical outcomes for residents and increased satisfaction.</p>

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End of the report.