

Knox Home Trust Board - Elizabeth Knox Home and Hospital

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](#).

The specifics of this audit included:

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| 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: 26 March 2018 End date: 28 March 2018 |
| 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: | 187 |

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 |
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|  | 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 |
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| | 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 around 30 younger people with a physical disability. The service is operated by the Knox Home Trust Board and managed by a chief executive officer. There have been no significant changes to the service and resident areas since the previous audit. The organisation continues its ten-year Eden Alternative journey, which provides the philosophy and framework for ongoing developments across the services. A new home for 22 residents adjacent to the current site is under development. Residents and families spoke positively about the care provided.

This certification audit was conducted against the 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, family members, management, staff, and two of the five general practitioners who provide services.

This audit has resulted in four continuous improvement ratings related to respecting individual values and beliefs, integration and links with the community, leisure and lifestyle activities and food services. Three areas are requiring improvement relating to individualising of service delivery plans, evaluations of care and medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

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

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Resident who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Māori health plan and related policies. The recognition of the individual's ethnic, cultural and spiritual needs and the celebration of these is well developed across the services. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Communication with residents and families is open and honest with active engagement of residents in decision making at individual and service development levels. Open disclosure following any adverse events was evident, when this was appropriate.

The service has strong linkages with a range of specialist health care providers. Strong associations with external agencies and with a wide range of community resources and services contribute to residents receiving care of an appropriate standard and enabling them to maintain links with the wider community. The service uses innovative ways to integrate residents in the community.

Complaints are well managed according to the requirements in the Code and seen as opportunities for improvement. Those reviewed were addressed sensitively and promptly.

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. | | Standards applicable to this service fully attained. |
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Strategic, operational and quality plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff and the large volunteer group is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information was accurately recorded, securely stored and not accessible to unauthorised people.

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. |
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A range of information that describes the scope of the services available and the Eden Alternative philosophy the organisation operates under is readily available. The organisation works closely with local Needs Assessment and Service Co-ordination Services, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

The organisation has moved to using the interRAI as its main assessment tool and this is being completed and updated appropriately by registered nurses (RN)s. Medical practitioners assessment and physiotherapy assessments and reassessments are also completed within appropriate time frames.

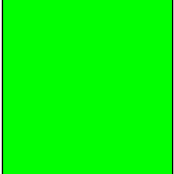
Electronic care plans are being completed on admission and six monthly, supplemented by short term care plans where required. All residents' files reviewed demonstrated issues, goals and interventions were identified, with the majority having personalised goals and interventions. Verbal and written shift handovers assist communication between staff on residents' care needs. 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.

The planned activity programme, overseen by a team of people with leisure and lifestyle expertise, provides residents with a variety of individual and group activities and maintains their links with the community. This is based on a community partnership model. A facility van is available for outings.

Medimap electronic medication management system has been implemented since the last audit. Medicine management has input from a local pharmacy and policies guide practice. Medications are administered by RNs and care partners, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

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. |
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire training. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. Enabler use is voluntary and intended for the safety of residents in response to individual requests, as well as according to an assessment. A comprehensive assessment, approval and monitoring process with regular reviews occurs prior to the use of a restraint, which is only used once other options have been explored. All enablers and restraints in use are documented on a register and regularly reviewed by a restraint committee. Staff receive training on restraint and enabler use and on de-escalation techniques for managing difficult behaviours. Reports on restraint and enabler use are provided to management for quality and risk review and for monitoring purposes.

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.

There is an appropriately qualified infection prevention and control RN who oversees the infection control programme. Policies and procedures guide good practice. Monitoring of infections are occurring and reported up through to the Board and to all staff at their meetings. Residents are involved in infection prevention and are kept up to date with bulletins.

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 | 3 | 44 | 0 | 3 | 0 | 0 | 0 |
| Criteria | 4 | 94 | 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](#).

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>Elizabeth Home and Hospital has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Residents and family members stated during interviews that these have not been breached.</p> <p>Clinical mentors and care partners interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices</p> | FA | <p>Nursing and care staff interviewed understand the principles and practice of informed consent. A recently reviewed policy and procedure on consent processes, including informed consent were reviewed and are used to provide relevant guidance to staff.</p> <p>Informed consent is obtained at the time of admission and covers residents' information, everyday care and treatment, use of photographs and outings. A separate clause in the agreement covers GP treatment. These are recorded and signed as part of the admission agreement. A separate form is used for influenza vaccinations and examples of completed copies of these were in some residents' files. Written consent for podiatry services was also on file.</p> |

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| and give informed consent. | | <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's record. According to care leaders, some residents have chosen not to complete an advance care plan. Enduring power of attorney documentation was in residents' files when available and records of their presence were on the electronic record system (VCare). Copies of forms that confirmed the person's preferences around resuscitation attempts had been signed by a medical practitioner and were evident in residents' files. There is a new process for the documentation of Not for Resuscitation (NFR), or otherwise, and the transition to the new forms is still underway. The VCare electronic record has an alert system to identify a resident's resuscitation status.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p> |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | FA | <p>Residents are given a copy of the Code, which also includes information on the Advocacy Service, when they are admitted to the service. A care leader informed that they talk about this service a few days after admission as there is too much happening on the first day.</p> <p>Posters related to the Advocacy Service were displayed in the facility, and additional brochures were available around the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Two family members interviewed provided examples of acting as an advocate for their relative.</p> <p>Clinical mentors and care partners spoken with were aware of how to access the Advocacy Service and of the use of themselves and family members as advocates. Examples of their involvement with residents were discussed and a clinical mentor advised that advocacy from family members is encouraged no matter how minor the issue may appear.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | CI | <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they feel welcome when they visited and comfortable in their dealings with staff. Staff, especially senior staff, consistently approach them and provide them with updates on how their family member is. A newsletter is produced quarterly and provides an overview of activities, updates from management and results of any surveys.</p> <p>Several residents spend overnights with their family members in their own homes. Four residents' family members spoken with, who take their relatives out overnight and/or at weekends, were complimentary and expressed their satisfaction with how this is being managed. However, this is not being clearly documented in the residents' care plans as noted in corrective action for criterion 1.3.5.2.</p> <p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the</p> |

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| | | <p>community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility supports the philosophy of The Eden Alternative and the active implementation of the associated principles, is demonstrating continuous improvement as each positive action and outcome is used as a foundation for a new option to be considered to further enhance the lives of the residents at Elizabeth Knox Home and Hospital.</p> <p>A wide range of examples of community partnerships were described by the leisure and lifestyle team. Photographs and reports were sighted and staff, resident and family member feedback about these partnerships were positive. The value of the large team of volunteers was also noted. There was good evidence, including resident survey results and of developments made on previous experiences and successes.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The complaints management policy and associated 'Issues, Concerns and Complaints Form' meets the requirements of Right 10 of the Code. Forms are sent to the quality coordinator either electronically via the electronic system VCare or in paper form for entry into the electronic system by the coordinator.</p> <p>Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. One person interviewed had used the complaint process and was happy with the process and outcome.</p> <p>The complaints register and a report from a review and analysis of all complaints over the past two years (March 2016 – February 2018) showed that 62 complaints had been received over that period. 'Lessons learnt' and follow-up action points are defined, with further work in progress around follow-up actions.</p> <p>Discussion with the care leader and quality coordinator and review of the electronic data base show that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. Examples noted included education and reflective practice exercises for staff involved. The quality coordinator is responsible for complaints management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and that they would try to resolve these at the lowest level.</p> <p>There have been no complaints received from external sources since the previous audit, including HDC complaints.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> | FA | <p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the information provided when they were admitted, from previous roles before they came into Elizabeth Knox Home and Hospital and from talks provided by other people from time to time. They were aware of weekly residents' meetings and some chose not to attend, while</p> |

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| <p>Consumers are informed of their rights.</p> | | <p>others have raised issues at these meetings and have had the issue discussed and resolved to their satisfaction.</p> <p>The Code is displayed in each home of the facility together with information on advocacy services. Details on how to make a complaint are in the admission agreement and feedback forms are available in each home and on request. Staff spoken with informed that verbal feedback processes are taken seriously.</p> <p>All family members interviewed were fully conversant with the Code.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | <p>FA</p> | <p>Residents and families confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>All staff understood the need to maintain privacy and were observed doing so throughout the audit. Personal cares were only undertaken behind closed doors, resident information is held securely in non-public areas and people were taken into another room to discuss residents' personal information privately.</p> <p>Residents have a private room, or they may share a room with their spouse. Each room has a privacy curtain, which allows staff to have a resident's room door open but to be able to quietly observe residents around the curtain. When a room is shared by people initially unknown to one another, consent is obtained and an example of this was in an admission agreement. There are dividing curtains to ensure residents' privacy.</p> <p>Residents are encouraged to maintain their independence by doing as much as they can for themselves, by going out into the community as they choose and to arrange to do the things they choose to do when they want. This was confirmed during interview and was especially evident during interviews with young people with disabilities. Each service delivery plan included documentation related to the resident's abilities, and strategies to maximise independence. Family members spoke of the advances their relatives have made towards being more independent while at Elizabeth Knox Home and Hospital. One described how a resident initially used a tube for feeding but is now able to swallow a soft diet. A resident spoke of the advances made in mobility and how this is being maintained and improved through daily visits to the gym.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. They were able to identify issues which could be considered as neglect of a resident and were aware of signs of abuse which a resident could demonstrate. No staff member had observed any behaviour of a resident which might identify an issue of abuse, nor had they observed any abuse of a resident. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records. No resident or family member raised any issue of abuse or neglect other than one raised and dealt with prior to the last audit.</p> |

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| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | <p>FA</p> | <p>Staff at Elizabeth Knox Home and Hospital informed that they have always focused on the needs of people from other cultures/ethnicities, including those who identify as Māori. Policy documents describe this commitment and a revised Māori health plan was reviewed.</p> <p>The principles of the Treaty of Waitangi are incorporated into day to day practice, with special emphasis on partnership, which is consistent with the Eden Alternative philosophy. A Kaumatua has recently joined the service and provides cultural advice when required. The importance of whānau to all residents is promoted with staff confirming that this is especially emphasised for Māori residents. Current access to resources includes the contact details of members of a local marae where additional cultural advice may be obtained.</p> <p>Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. A Māori resident was interviewed and acknowledged the Kaumatua is now available for support, expressed satisfaction with the level of cultural input and noted that access to other serves is available as desired. It was confirmed that whānau are involved and welcome.</p> <p>Evidence was sighted that staff receive training on Māori values and beliefs and on the Treaty of Waitangi. A process for blessing rooms when a person passes away is in place and residents are involved. There is a welcome and leaving ceremony for all residents, regardless of culture or ethnicity, however a staff person who identifies as Māori noted how especially important this is for residents who identify as Māori.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | <p>CI</p> | <p>Residents verified that they were consulted on their individual culture, values and beliefs. These details were recorded in the hard copy and electronic versions of the residents' service delivery plans that were reviewed. Related personal preferences, required interventions and special needs were well documented. A policy document titled 'Cultural Responsiveness Framework' describes staff responsibilities in this area.</p> <p>The acknowledgement and celebration of ethnic / cultural diversity and spirituality are other areas in which Elizabeth Knox Home and Hospital is demonstrating continuous improvement. There have been multiple cultural celebrations, celebrations of cultural festivals, use of internal and external resources to support residents culture, values and beliefs, food provision acknowledging the cultural diversity of residents and staff, new and increasing access to church attendance and fellowship opportunities and an overall partnering between residents and staff to ensure that residents' needs are being met more holistically. These increasing opportunities are consistent with the Eden Alternative philosophy that underpins the operations of this service.</p> |
| <p>Standard 1.1.7: Discrimination</p> | <p>FA</p> | <p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of</p> |

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| <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | | <p>services provided to residents and the skills and knowledge of the registered nurses.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. Staff are provided with a Code of Conduct and ongoing education on the Code and expectations of professional behaviour is being consistently provided and documented in staff training records.</p> <p>Policies and procedures guide staff and during interviews with care partners and care leaders, all were aware of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | <p>FA</p> | <p>Elizabeth Knox Home and Hospital has had full Eden Alternative registration since 2014 and there was good evidence of ongoing developments with the programme, especially regarding community partnerships. The service encourages and promotes good practice at all levels and there were multiple examples of this occurring. Continuous improvement has been specifically acknowledged in relation to cultural and spiritual issues, links with the wider community, activities (leisure and lifestyle) and meals.</p> <p>Evidence based practices are upheld and specialist input, such as from physiotherapists, diabetes nurse and wound specialist is accessed when indicated. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required, staff were responsive to medical requests and that staff overall have high levels of skills and knowledge.</p> <p>Services are being carried out at a high standard, which was also confirmed by residents and family members. Residents and staff described the organisation as one large family. Staff also reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit include the recruitment of an expert infection control nurse; the review and restructure of nursing leadership with the appointment of a clinical nurse educator, a care leader and clinical mentors. A physiotherapy programme that involves three qualified physiotherapists over 49.5 hours Monday to Friday and 95 hours per week of physiotherapy assistant time enables all residents to receive almost daily physiotherapy input; a volunteer programme is in place and supports the life and leisure programme; there are home based work teams, which increase continuity for residents and create a more home-like model of care and a new van has been accessed through grant funding as a result of one of the community partnership process.</p> |
| <p>Standard 1.1.9: Communication</p> | <p>FA</p> | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, 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 where there is a form to indicate all</p> |

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| <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | | <p>family contacts. The Eden Alternative model of care used at Elizabeth Knox aims to empower residents to express their own opinions and be part of the decision-making process. This is facilitated through weekly residents' Eden Alternative meetings run by the CEO and involvement of residents in projects and decisions (eg, food services).</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. An example of open disclosure following a medication error was discussed with the care leader and related documentation reviewed in the clinical record.</p> <p>Elizabeth Knox has a diverse cultural mix of staff, residents and volunteers. There are 68 cultural groups represented in the volunteer group and 25 within the staff group. A list of all staff and the languages they can speak is available and staff are used to support residents and families in their day to day interaction and when needed. In addition, formal access to interpreter services is available.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>The Elizabeth Knox Home and Hospital was established in 1911 and maintains the traditions and values defined by Elizabeth Knox to provide high quality care to both younger physically disabled and older people. The vision statement, mission statement and values are defined and reflect the Eden Alternative philosophy. The governing body of the Trust (seven members) sets the strategic direction and this is supported by an operational/quality plan, which is reviewed annually. The documents described annual and longer-term goals. A sample of monthly reports to the board of directors showed adequate information to monitor performance is reported including financial performance, emerging risks and issues, incidents and complaints, minutes from the care and quality forum and reports from other key groups. A member of the board and the board as a whole were interviewed and reported the adequacy of the information provided.</p> <p>The service is managed by an experienced and well qualified CEO who has been the CEO for over 10 years. She was recently recognised by the New Zealand Aged Care Association (NZACA) through the Excellence in Care Outstanding Individual Award for her ongoing leadership and commitment to the Eden Alternative philosophy. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CEO confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through links within the local community, nationally and internationally.</p> <p>The service holds contracts with Auckland District Health Board (ADHB) for long term hospital and rest home care and respite care, and with the Ministry of Health (MoH) for residential care for younger people with a physical disability (YPD). There is one YPD resident who receives an individual funding package and one individually negotiated package for a resident through the ADHB. This is for review after a three-month period. All beds are 'swing' beds, able to be used for hospital or rest home care. At the time of audit, there were 152 residents receiving hospital level care and 35 residents receiving rest home level care. Of these, 23 were aged under 65 years of age (YPD).</p> |

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| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | <p>FA</p> | <p>When the CEO is absent, the commercial manager carries out all the required duties under delegated authority. The care leader takes overall responsibility for the clinical management of the service. This person has been in the role for around four months and is well qualified and experienced in the sector and in senior nursing leadership roles. She is supported by a medical director, clinical mentors, the physiotherapy team leader, occupational team leader, a quality coordinator and a newly appointed clinical nurse educator. During absences of the care leader, clinical mentors take responsibility for clinical oversight. There is a strong commitment to resident-directed care and a flattened, non-hierarchical management structure.</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>FA</p> | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement and is guided by the Operational and Quality Plan (2018) and the Eden Alternative ongoing developments. The Operational and Quality Plan is reviewed yearly with measures/performance indicator against goals. The quality programme/framework includes management of incidents and complaints, audit activities, resident and family satisfaction surveys, monitoring of outcomes, including infections. The quality coordinator (an 'acting' role at the time of audit, due to the recent resignation of the previous coordinator) oversees the programme and compliance with legislative requirements and the organisation's values. Elizabeth Knox is also part of the Australasian accreditation 'EQuIP6' (Evaluation Quality Improvement Programme).</p> <p>Meeting minutes of the key quality forum (Care and Quality) reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at senior management meetings, the Quality and Risk Sub-committee of the board and the board. Elizabeth Knox is also part of the 'QPS' benchmarking programme. Staff reported their involvement in quality and risk management activities through audit activities, improvement projects and from information shared at staff meetings. Residents are also involved through a range of projects (eg, the food service, the leisure and lifestyle programme, issues-based satisfaction surveys) consistent with the resident driven care philosophy.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. Family satisfaction surveys are completed annually, and resident satisfaction surveys regularly related to specific areas. The most recent resident experience survey (completed in March 2018 by an external consultant), focused on loneliness, boredom, quality of life and end of life preparedness. This showed a positive environment and high quality of life. Recommendations as a result of findings are in the process of development. The family survey, completed in November 2017, showed that 98% of relatives were generally satisfied with care.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference</p> |

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| | | <p>to the interRAI Long Term Care Facility (LTCF) assessment tool and process. The policies identified as requiring some improvements as part of the first stage audit process were reviewed on site and all met requirements. Policies are based on best practice and were current. The document control system has been reviewed over the past year and the numbers of documents reduced significantly to reduce duplication and simplify content. There is now a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The CEO and the quality coordinator described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk register demonstrates regular review of risks, and up to date register, and identification of key risks with relevant mitigation actions. The board, CEO and the health and safety coordinator interviewed were familiar with the Health and Safety at Work Act (2015) and have implemented requirements, with a further review pending in the near future in relation to management of external contractors. Elizabeth Knox continues to be part of the ACC Workplace Safety Management Programme.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | FA | <p>Staff document adverse and near miss events on an accident/incident form or directly into the electronic system. The process follows that defined in the Adverse Events Management Policy and Procedure. A sample of incidents reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to several groups including the Care and Quality Group, the board Quality and Risk Sub-committee and the board and with several indicators benchmarked as part of the QPS indicator programme.</p> <p>The CEO, care leader and quality coordinator described essential notification reporting requirements, including for pressure injuries. Those related to adverse events are defined in the Adverse Events Management Policy and Procedure. There have been no police investigations, coroner's inquests, issues-based audits since the previous audit.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of</p> | FA | <p>The human resources management manual covers all aspects of recruitment and employment and is based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. Residents are part of the interview panel for all employees and have the right to veto any appointment. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are well maintained.</p> <p>There are around 800 volunteers at Elizabeth Knox overseen by two volunteer coordinators. Volunteers all complete a systematic employment process which includes either a one on one or small group interview, application documentation, role description and offer of work. Most volunteer work is related to providing</p> |

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| legislation. | | <p>companionship to residents and supporting residents and the team during meals. Volunteers work as part of the team, alongside staff members. A full orientation programme covers health and safety and the essential components of the role and life at Elizabeth Knox. Ongoing education is provided on a regular basis and a three monthly one on one meeting is held with each volunteer to support them in their roles and identify any areas of need. A coordinator is on call should this be required. All volunteers are required to 'sign in' and 'sign out' using the electronic system. One of the coordinators interviewed demonstrated the process and the ability to know at any time what volunteers are on site and where.</p> <p>Staff orientation includes all necessary components relevant to the role and those interviewed reported that the three-month orientation process prepared them well for their role and that they have a 'shadow' person until they felt confident in their role. A recent focus on improving orientation has seen the development of the care-partner guide and RN guide to help staff better 'settle in' to their roles and the 'Elizabeth Knox way'. Staff records reviewed showed documentation of completed orientation.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. The new clinical nurse educator oversees the training programme. There has been a change to a yearly two-day training programme for all staff to ensure that all requirements are covered. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Two staff members are internal assessors for the Careerforce programme, one of them being the clinical nurse educator. There are sufficient trained and competent registered nurses (nine) who are maintaining their competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals or a scheduled review date for those yet to complete this. Staff interviewed felt well supported with training opportunities, including registered nurses. Specific training relevant to the resident group has also been offered (eg, 21 team members attended the Dementia Beyond Drugs workshop run by Dr Allen Power at the end of 2016). First aid and medicines competency records were reviewed and demonstrated sufficient staff have completed requirements in these areas.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. Staffing rosters have been reviewed over the past year within each of the home areas with involvement of the care partners and residents. There is a move towards longer shifts, a reduction in short shifts and/or split shifts, and staffing based around each smaller 'home base', consistent with the Eden Alternative principles. Observations and review of a roster cycle confirmed adequate staff cover has been provided. There has also been a focus on reduction of external bureau use with an internal bureau/team of staff available (rostered) on each shift to provide cover for any unplanned leave or where an increase in staffing might be required. There is also an Elizabeth Knox casual pool if staff is required over and above this. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN</p> |

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| | | coverage. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care partners reported there were adequate staff available to complete the work allocated to them and they felt well supported by the RNs and managers. Residents and family interviewed supported this. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This included interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held off site by a contracted records storage company and can be accessed should they be required. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| 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 | Referrals to the Elizabeth Home and Hospital may be received from any health and disability service, a family member or a person may self-refer. Residents may only enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Details about the services provided in this facility, especially about the Eden Alternative, are available on a website, Eldernet, brochures from reception and from other local health and disability services. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the care administrator, who is the key person responsible for the formal pre-entry and admission process and for explaining costs, activities, meal arrangements and the Eden Alternative, for example. People are encouraged to go in and have a meal and/or attend day activities prior to becoming a permanent resident if this is possible. The Chief Executive Officer (CEO) described the liaison process with admissions from the local District Health Boards, especially for more urgent admissions and use of the two funded respite beds. Referrals are reviewed by members of the senior management team with the care leader responsible for the final decision. A waiting list for entry is in place. Family members and residents interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The care leader, acting quality coordinator and RNs interviewed described the process of ensuring good transfer of information when a resident is being transferred to another provider. This included the 'yellow |

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| <p>Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | | <p>envelope' which list the information being sent. The care leader spoke of regular meetings with the DHB and other health service providers where information is shared and issues such as transfer documentation is discussed. Three residents who had been to hospital had good evidence of transfer of information and one example of additions to the care plan post from the hospital with copies of the discharge information for the resident in the file.</p> <p>There is evidence in two files of management of residents who wished to transition home and how this is being managed with input from the Needs Assessment and Service Coordination service (NASC) and gerontology service.</p> <p>There is good evidence, documented and anecdotal, of how transfers home are managed to ensure safety and if issues arise while the resident is out of 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 requirements and safe practice guidelines.</p> | <p>PA Low</p> | <p>A medication manual covers all aspects of medication management, in line with the Medicines Care Guide for Residential Aged Care. Standing orders are in use for a range of medications and these were reviewed early this year. However, these do not meet the requirements outlined in the Ministry Standing Orders guidelines.</p> <p>A local contracted pharmacy provides monthly pre-packaged rolls of medication, which are checked against the prescription by a RN on arrival at the facility. Some organisation stock items are also available including a range of emergency medications.</p> <p>The electronic Medimap system was implemented this month (March). Staff confirmed they had received training on the system. A GPs spoken with stated the GPs have embraced the Medimap process. The staff observed in medicine administration activities demonstrated good knowledge and had a clear understanding of their roles, knowledge of the Medimap process and responsibilities related to each stage of the process. RNs and some care partners undertake medication competency annually to be able to administer medications. The care leaders spoke of commencing audits using the inbuilt Medimap monitoring system, but it was early days for this to commence.</p> <p>Safe storage of medications was observed, and a sample of medicines reviewed were within current use by dates, with the exception of two ampules on the emergency trolley. Medication fridges have temperature monitoring; however, one had recording over the maximum requirements. Controlled drugs are stored securely in accordance with requirements. The controlled drug register records administration by two staff. Weekly checking is undertaken, and pharmacy undertake a six-monthly stock checks and accurate entries. However, the mandatory quantitative stock checks were not being undertaken. The infection control clinical nurse specialist, stated that they will be storing the influenza vaccine for GPs. She is aware of the storage requirements and is in the process of seeking accreditation for the storage. No vaccines were presently being stored.</p> <p>The medication policy states residents can self-administer medications. One resident is presently under</p> |

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| | | <p>supervision with medications and this is being reviewed on a three-monthly basis with the GP.</p> <p>Medication errors are recorded on an accident/incident form and reported in the electronic system, monthly reports with trending were sighted.</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>Food services are provided on site by an external contractor, which supplies a qualified chef and kitchen team. Meals are provided in line with recognised nutritional guidelines for older people. The menu rotates over six weeks and a report on the 2017-2018 summer menu following review by a qualified dietitian was sighted. Recommendations made at that time have been implemented. It was reported that a winter menu is currently under development and sections of a draft were sighted.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Residents' personal food preferences, any special diets and modified texture requirements are made known to kitchen staff, placed in a visible position in the kitchen and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available and were seen to be in use during the meal times. Residents weights are monitored monthly, or more frequently when indicated. Registered nurses check these for any significant changes and if necessary take appropriate action such as accessing high calorie products for the person.</p> <p>Evidence of 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. Staff are redeployed during mealtimes, which is enabling sufficient staff to be on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p> <p>A series of complaints about the meals was raised several years ago and management made a commitment to address the issues. There is now continuous improvement evident the way residents' food preferences and any nutritional needs are managed, while at the same time choices are being made available and high quality and well-presented meals are supplied.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Ministry of Primary Industries with a registration certificate dated January 2018. Fridge and freezer temperatures and food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Food storage and disposal processes are consistent with requirements of the plan. The food services manager has undertaken a safe food handling qualification for which evidence was sighted. Kitchen assistants have completed relevant food handling training.</p> |

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| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | <p>FA</p> | <p>The CEO described the lengths that staff at Elizabeth Knox Home and Hospital go to that ensures prospective residents will be suitable for the care and support provided at this facility. If a referral is received, but the prospective resident does not meet the entry criteria, or there is no vacancy at the time, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. Prospective residents are required to sign the admission agreement and to make prior payment before entry to the service. The CEO stated that if even one of these requirements is not met, then entry will be refused, and the person would be referred back to the NASC.</p> <p>If the needs of a resident change and this service provider is no longer suitable for the services offered, a referral for reassessment by the NASC is made and a new placement found, in consultation with the resident and whānau/family. The CEO noted that this is a rare event as unless the person requires specialist mental health or more advanced dementia care then every effort is made to meet their needs within the parameters of the needs assessment. There is a clause in the access agreement related to when a resident's placement can be terminated.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | <p>FA</p> | <p>Information is gathered using validated assessment tools, the organisation has moved to the interRAI for most of its assessments. These are used to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. The interRAI assessment history of several residents was reviewed and showed pre-admission and admission plus six monthly assessments being undertaken. All residents have a current interRAI assessment. All residents' files reviewed had an initial plan of care and social assessment. VCare plans are in place and reviewed six monthly. Evidence was sighted of the use of pressure injury assessments including ongoing photographs and head injury observations form.</p> <p>Monthly monitoring of observations such as blood pressure, pulse, oxygen saturation and weight were sighted as being undertaken, however actions from these were not consistently sighted (See CAR 1.3.5.2).</p> <p>Assessments were undertaken by the multidisciplinary team, including physiotherapists, occupational therapists and medical practitioners. Specialist assessment or mental health assessment from DHB specialist services are requested appropriately and undertaken when required. An example of a resident who has weekends at home had a detailed assessment of the home for these visits to occur in a safe manner.</p> <p>Residents and families confirmed their involvement in the assessment process.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are</p> | <p>PA Low</p> | <p>VCare plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Short term care plans being used to supplement the care requirements, examples sighted included, wound care, urinary tract infections, vomiting and respiratory infection. The most recent VCare plan is to be printed off and placed in the residents file along with</p> |

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| <p>consumer focused, integrated, and promote continuity of service delivery.</p> | | <p>other relevant documentation. This allows care partners to view the care plan document. This was confirmed by RN and care partners interviewed.</p> <p>Review of 21 residents' VCare and hard copy files, showed integration of the assessment process, detailed documented progress notes, GP and allied health team records being kept in the one file. Any change in care required is documented in the progress notes, shift hand over sheet and verbally passed on to relevant staff at shift handover. An issue was identified related to ensuring that the individual needs of residents are being documented in the VCare plan.</p> <p>Residents and family members reported participation in the development and ongoing evaluation of care plans. A family meeting is the forum to document this review of care each year.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>The philosophy of the Eden Alternative was observed as being fully implemented in the service delivered to the residents. Staff titles reflect the partnership with the residents such as care partners and life enhancers. Staff interviewed were able to state how they implemented the philosophy to support independence and stated that they were all part of the family of Elizabeth Knox. They follow the direction of the RNs, the documented care plan, and any changes are communicated at hand over. It was observed that volunteers were bountiful in assisting residents and staff. Documentation and interviews with residents and family members verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. This included the diverse needs of residents and their engagement and integration with the community and expanding their horizons in areas of interest.</p> <p>Two GPs interviewed verified that medical input is sought in a timely manner, that staff used the situation, background, assessment, recommendation (SBAR) communication tool and had observations ready for the when they were called to see a resident. Medical orders are followed, and care is delivered in a timely manner. Medical advice is appropriately sought.</p> <p>There is a suitable range of equipment and resources are available, suited to the level of care provided and in accordance with the residents' needs.</p> <p>Interview with residents and families confirmed 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</p> | <p>CI</p> | <p>The activity programme at Elizabeth Knox Home and Hospital, otherwise known as Leisure and Lifestyle, is led by a leisure and lifestyle coordinator and an assistant with further support from the significant team of volunteers. Its content is discussed at the minuted residents' meetings and residents' feedback is a key factor in planning not only the structured programme, but other types of recreation to be made available. The structured activities programme enables residents who for one reason or another cannot get out of the facility</p> |

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| <p>for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | | <p>as easily, to be more gainfully occupied. Friends and family/whanau are welcome to participate as they choose. Overall, activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Because of the philosophy of the Eden alternative, there is an emphasis on spontaneity and opportunity.</p> <p>On admission to the facility, a personalised social assessment and history called 'Who I am' is completed. It was reported that this is preferably completed by the resident, or by family/whanau, but if necessary a staff will do this with the resident and a family member. Residents' involvement in completing the form was evident. The information obtained helps staff become familiar with residents' needs, interests, abilities and social requirements. Documented individualised goals and interventions are holistic, albeit they are less specific and more generic. Residents' levels of participation are monitored and are reviewed six monthly as part of the regular care plan and service delivery review.</p> <p>An acknowledgement of continuous improvement has been made for this standard as there is a diverse range of activities on offer, all feedback processes are positive, there was an atmosphere of 'energy' while residents were occupied in different ways and ongoing improvements are being made as a result of the information obtained from the multiple evaluations and reviews of the type, frequency and environment in which leisure and lifestyle opportunities are offered and provided.</p> |
| <p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>PA Low</p> | <p>Residents' files reviewed provided evidence of evaluation occurring daily, or more frequently if required, this is recorded in the progress notes. RNs and care partners report changes to care are communicated at handover in writing and verbal.</p> <p>Formal evaluation of the plan of care occurs every three months with medical staff and six monthly using the InterRAI assessment by the RN. The assessments are then used to review the residents electronic VCare long term care plan. A hard copy of which is put into the resident's manual file. Review of the residents file showed that not all goals were being evaluated. Annually there is a multidisciplinary review, which includes resident and family member input, these were sighted in most files, however not all files contained this formal review. Where issues are identified a short-term care plan is initiated, these are usually reviewed monthly and ongoing issues added to the long-term care plan. However, the hard copy of short term care plans sighted in some resident's files did not have the review and closure documented.</p> <p>Residents and family members stated they felt involved in the evaluation of care, and that staff communicate changes to them on a regular basis.</p> |
| <p>Standard 1.3.9: Referral To Other Health And</p> | <p>FA</p> | <p>Residents are supported to access or seek referral to other health and/or disability service providers. A team of five general practitioners provide a service to residents, who may choose to use another medical</p> |

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| <p>Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | | <p>practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Evidence was sighted of referral to internal and external providers. Examples included; internal to occupational therapy for assessment and plan for a resident home visits. Multiple examples of external referrals to specialists, such as mental health, podiatry and gerontology, with an example of three residents having been referred and admitted to hospital. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | <p>FA</p> | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and two staff interviewed knew what to do should any chemical spill/event occur. There were spill kits available.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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>A current building warrant of fitness (expiry date 28 September 2018) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with the maintenance manager and observation of the environment. There are 19 lifting hoists in use across the service and all have been maintained according to the manufacturers information. At the time of audit, two ceiling hoists are being trialled in preparation for possible installation in the new building underway. The environment was hazard free, residents were safe, and independence is promoted.</p> <p>A new 'back of house' redevelopment has seen an increase in office space and meeting rooms for staff and extra space for equipment and the maintenance team. This area has controlled electronic access for staff only.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. A gardener is employed three days a week to maintain the external areas, including pathways.</p> |

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| | | Staff confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned, and residents interviewed were happy with the environment, and in particular the many options for outside sitting and gathering and the dining areas. |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility, with each room having their own ensuite. Additional toilet facilities are available near common areas and for use by visitors. There is a 'bed bath' available for use which can be wheeled into the bathroom areas. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | FA | <p>Although some bedrooms are smaller than others, adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are four bedrooms across the site that can be used as double rooms. Where rooms are shared approval has been sought. Rooms were personalised with furnishings, photos and other personal items displayed.</p> <p>Many of the younger people have mobility aides, electric and other wheelchairs and there is room to store these. Staff and residents reported the adequacy of bedrooms.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity,</p> | FA | The site has many communal areas available for residents to engage in activities, entertain visitors and sit outside or in more private spaces. The dining and lounge areas are spacious and enable easy access for residents and staff. Most of these areas are attached to each of the home areas and are set up to model a domestic homely environment. Residents can access areas for privacy, if required. Furniture was appropriate to the setting and residents' needs and was well maintained. The facility is divided into five homes with two levels in one of the homes. Access between these two areas is via stairs and a lift. A carpet replacement programme has seen new carpets in several lounges and dining areas. |

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| and dining needs. | | |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | FA | <p>Laundry is undertaken on site in a dedicated laundry by a contracted provider. The laundry runs between 6 am and 9.30 pm daily. In addition, in one of the homes (Nikau) there are three small domestic laundries for residents and/or families to wash smaller items. Residents are assisted by 'home makers' in these areas with washing. Guidelines are available for this process. The infection control specialist nurse has reviewed and audited the main laundry (September 2017) and improved the dirty to clean workflow and delineation. She reported that the laundry now functions very effectively and efficiently. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty to clean flow and handling of soiled linen. They have been trained in the Careerforce infection control module and other relevant training for their roles. There were no complaints received in relation to management of the laundry from residents and family members interviewed.</p> <p>Home makers in Nikau are also responsible for cleaning and the one home maker interviewed reported this works well. Cleaning of the rest of the facility is a contracted service with a dedicated cleaning team on site seven days a week. Those interviewed were able to describe cleaning procedures. Chemicals were stored in lockable cupboards.</p> <p>Cleaning and laundry processes are monitored through the audit programme. The infection control specialist nurse completes audits along-side contracted and Elizabeth Knox staff. The facility was clean and tidy during the audit period.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | FA | <p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 18 July 2014. A trial evacuation takes place three-monthly with a copy sent to the New Zealand Fire Service, the most recent being on the 15 February 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the possible 191 residents. Water storage tanks are located around the complex, and there are now two generators on site; one a recent addition to support the additional 'back of house' functions. Emergency lighting is regularly tested. This was discussed with the maintenance manager.</p> <p>Call bells alert staff to residents requiring assistance and were available in all resident areas. With one exception reported by a resident's relative during the audit, call bells were reported to be answered promptly. This comment was followed up by the manager. The time to answer can be tracked and monitored at any point should there be a query or concern. There have been two complaints raised in relation to call bell responses</p> |

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| | | <p>over the past two years.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night. There are security cameras monitoring common areas and external areas. Review and revision of access control has seen increased electronic controlled access to many parts of the facilities.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto outside garden or small patio areas. Heating is provided by electric heaters in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>There is an infection control co-ordinator (ICC), who is employed eight hours a week with the responsibility for infection prevention and control. She has been in the role for a year and has a current job description. Two care partners have agreed to be infection control champions, led by the ICC. The ICC has developed an Annual Infection Control programme, the 2018 programme. There is an infection control committee whose terms of reference were signed off in March 2018 and they will meet monthly. Membership includes, care leader, RN guide, volunteer coordinator, physiotherapist and a GP. Infection control surveillance activities are recorded on the monthly summary of quality activities and in the monthly and quarterly Quality Performance Systems (QPS) reports. Reporting of infections and trends go through to the Board.</p> <p>Systems are in place to monitor infections and steps are taken to minimise risks to residents and other staff. Examples of these were recent gastro outbreak and a staff member who was identified as having an infectious disease while at work. Both were managed appropriately.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and</p> | FA | <p>The infection control coordinator was interviewed. She is a RN with a post graduate qualification in infection prevention and control and works part time at the local DHB as an infection control clinical nurse specialist and also works at a local hospice. She has over 20 years' experience in infection prevention and control practices.</p> <p>Through her work at the DHB she has access to a range of infection control specialists and laboratory test results to monitor infection rates for Elizabeth Knox Home and Hospital (EKHH).</p> |

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| information resources to implement the infection control programme and meet the needs of the organisation. | | The ICC confirmed the availability of resources to support the programme and any outbreak of an infection |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>There are range of infection policies and procedures that reflect the requirements of the infection prevention and control standard, current accepted good practice and appropriate to the size and type of organisation. The ICC has reviewed all the policies this year to ensure current good practice. These include, hand hygiene, standard precautions, outbreak management, waste management, antimicrobial stewardship and multidrug-resistant organisms (MRO).</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as good handwashing, appropriate use of disposable aprons and gloves. Staff interviewed verified knowledge of infection control policies and practices. Hand washing and sanitiser dispensers are readily available around the facility.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | <p>Interviews, observation and documentation verified staff have received education in infection prevention and control. The ICC has developed an infection control orientation package and all new staff employed in the last six months have undertaken this training. Infection control is part of the ongoing mandatory training of staff and a package for ongoing training is underdevelopment. Two ad hoc training sessions have been undertaken related to hand hygiene.</p> <p>Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. Residents are part of outbreak management as confirmed by one resident and copy of the outbreak management process was sighted in one residents file. Evidence was sighted of consent for influenza vaccination.</p> |
| Standard 3.5: Surveillance | FA | Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, eye, gastro-intestinal, the upper and lower respiratory tract. The infection control programme |

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| <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>2018 outlines the surveillance activities as; hand hygiene compliance and methicillin-resistant staphylococcus aureus or extended spectrum beta (β) lactamase per 10,000 patient days. Clinical indicators are reported in the monthly quality activities report with trending data going back to 2016. The ICC reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The care leader provided evidence of the report showing the February figures with a breakdown by infection type. The ICC spoke of liaison with the two local laboratories to ensure individual resident infections are identified and monitored. QPS benchmarking of infections is also undertaken with data showing the organisation's trends and variations against other like organisations.</p> <p>A summary report for a recent gastrointestinal infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been 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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator and the restraint minimisation committee provide support and oversight for enabler and restraint management in the facility. During a meeting to discuss restraint and enabler use, the committee members demonstrated a sound understanding of the organisation's policies, procedures and practice and their roles and responsibilities.</p> <p>On the day of audit, 15 residents were using restraints and 58 residents were using enablers. Restraints and enablers in use were primarily groin 'Y' belts, tilted space/comfort chairs, lap belts in motorised chairs and bed rails. The use of low beds is being further investigated. Similar assessment, review and evaluation processes are followed for the use of enablers as are used for restraints. These are robust and ensure the on-going safety and wellbeing of the residents are key considerations. Specific procedures have been developed to improve safety and include that no lap belts are to be used with lazy boys, or similar lounge chairs and that the shoulder belts that the comfort chairs come with are removed, for example.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes and files reviewed of those residents who have approved restraints and from interview with staff.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of</p> | <p>FA</p> | <p>The restraint committee, made up of a senior physiotherapist, a registered nurse guide, a care partner guide and a nurse educator, is responsible for the approval of the use of restraints and the restraint processes, as defined in policy. A care leader is also a member and is now the restraint coordinator. Organisational policies and procedures state this committee will meet monthly; however due to staff changes and outcomes of recent reviews, the committee is currently meeting two weekly and there was evidence of this currently occurring.</p> |

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| <p>restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> | | <p>It was also evident from review of restraint approval group meeting minutes, review of residents' files and during interview with the coordinator that there are clear lines of accountability, that all restraints have been approved, and that individual and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making, as is required by the organisation's policies and procedures, is in residents' files as applicable. The use of a restraint or an enabler is included in the care planning process and documented in the plan of care.</p> |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | <p>FA</p> | <p>Assessments for the use of restraint were documented and included all requirements of the standard. The initial assessment is undertaken by a registered nurse with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA, as applicable. A registered nurse and the restraint coordinator described the process and a family member confirmed their involvement.</p> <p>The general practitioner is involved in the final decision on the safety of the use of the restraint. Documentation sighted shows that the assessment processes identify the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. Completed assessments were sighted in the records of residents who were using a restraint as well as those using an enabler.</p> |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p> | <p>FA</p> | <p>The use of restraints is actively minimised, and the restraint committee members described how alternatives to restraints are discussed with staff and family members. Time is spent explaining how the resident can be safely supported and suitable alternatives, such as the use of sensor mats and altered call bells are explored before use of a restraint is implemented. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records contain the necessary details, access to advocacy is available if requested and all processes ensure dignity and privacy are maintained and respected. Such details are included in the resident's care plan and monitoring forms reviewed recorded that this is occurring as required.</p> <p>A restraint register is maintained and updated every month (currently two weekly) at the restraint committee meetings. The register had been reviewed during the month of the audit, it contained all residents currently using a restraint and sufficient information to provide an auditable record. During the last review, three residents had had bedrails replaced by bed levers, which are increasingly being encouraged as a safer option to bed rails and one that increases independence.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as the benefits of using four-point restraint devices to maintain posture. Staff spoken to understand that the use of restraints is to be minimised and were aware of how to maintain safe use.</p> |

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| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p> | <p>FA</p> | <p>Records of restraint use, and its ongoing monitoring, were in residents' files. Review of residents' files also evidenced that individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, monthly restraint committee evaluations, and if a person's condition changes. One family member interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation includes all requirements of the standard and possible options are explored.</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>The restraint committee undertakes review of all restraint use at its monthly (currently two weekly) meetings. A report is developed by the care leader/restraint coordinator who provides it for inclusion in the following monthly care and quality committee meeting. In turn, the Chief Executive Officer presents the information to the Board. Evidence of these reports was sighted. The care leader provides the information to the care teams, alongside individual restraint use, and discusses issues raised with the care partners. Any training requirements are identified with an example being that in March 2018 the restraint training for new staff had been updated in their orientation package.</p> <p>Minutes of meetings confirmed the reviews of restraint use include analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. Any restraint related incident is also reviewed. InterRAI reports had been used for benchmarking restraint use with that of other facilities and the reasons for higher numbers had been analysed and discussed. Conclusions had been reached and reflected the focus on lifestyle, resident safety and in some cases resident comfort and independence.</p> <p>Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews confirmed that the review of use of restraint is ongoing.</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) |
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| <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>There is a comprehensive medication management manual which covers all areas of management. The move to Medimap, commenced this month and has gone smoothly with staff reporting that they are happy with the process. A number of standing orders have been signed off by the five GPs earlier this year and staff with current medication competency use these when required. The standing order process does not meet the Ministry of Health Standing Orders Guidelines, specially; where the administration will be documented in the clinical notes, weather the standing order will be countersigned by the GP, or if monthly auditing will occur, define the terms/definitions used such as BD, TDS, STAT, these are not defined in the medicine manual either.</p> <p>Review of the storage of medications was undertaken in each area and meet good practice. It was observed medication that require refrigeration are being stored appropriately and daily fridge temperature monitoring is undertaken. One fridge has recorded at 10 degrees for four consecutive days with no action</p> | <p>The controlled drug register does not show that the mandatory six monthly quantitative stocktake has occurred.</p> <p>One medication fridge had its temperature recorded for four days, over the recommended temperature and no action had been taken.</p> <p>There are standing orders which do not meet the requirements of national guidelines.</p> <p>Documentation</p> | <p>Standing orders are reviewed to meet the guideline requirements.</p> <p>The medication fridge temperature process is reviewed to ensure staff are aware of the temperature requirements and action to be taken when the temperature is outside the normal limits.</p> <p>Staff undertake the mandatory controlled drug checks six monthly.</p> |

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| | | <p>recorded or retesting of the temperature those days to see if it was an anomaly.</p> <p>Controlled Drug storage is appropriate, the registers are being completed appropriately and consistent weekly checking is being undertaken. The contracted pharmacy also undertakes an audit, six monthly (April and October), of the controlled drugs. This includes all balances are correct, RN signatures are recognisable, and designations recorded, and any discrepancies noted and action to be taken and by whom. The last two audits showed positive results. However, there is no documentation of the mandatory six monthly (June and December) quantitative checking occurring.</p> | <p>provided following the audit demonstrated that all three areas have been addressed with systems developed to ensure ongoing compliance with requirements.</p> | <p>180 days</p> |
| <p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p> | <p>PA Low</p> | <p>The electronic VCare system is used for the plan of care and identifies issues, set goals and interventions, the most recent plan is printed out and available for all staff. The individual plan is updated six monthly with short term care plans being used when required. The VCare plans have several prepopulated goals and interventions which were seen as the main stay of the plan of care. This is seen as appropriate by the organisation such as the use of the national agreed tools for falls prevention. However, a number of examples of residents who have individual needs not have these detailed in the plan of care.</p> <p>Examples sighted:</p> <ul style="list-style-type: none"> - one tracer who has regular home visits had no detail in the care plan of the requirements of these visits. - one of the tracer files identified a weight gain problem identified but no detail of the overall actions being taken to manage this issue were documented. - a resident oxygen saturation was documented as 94 for two months. The resident did have a chronic respiratory disease, but there is not documentation in the long term care plan that the GP were being informed and were happy with the resident being at this level. | <p>The organisation uses the electronic VCare system for their service delivery planning. During the file review, there were examples of service delivery plans that lacked individualised details. Examples included, catheter cares, restraint, behaviour management and preparation for home visits.</p> | <p>Service delivery plans document the required supports and interventions related to the individual needs of the residents.</p> <p>180 days</p> |

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| | | <ul style="list-style-type: none"> - residents with ongoing pressure injury management issues, did not have this identified in the long term care plan. - scant detail on catheter care, including changes. - one tracer with significant behavioural challenges care plan lacked detail on behaviour management strategies. However, staff are recording behaviour incidents well despite this not being noted in the care plan interventions. | | |
| <p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p> | PA Low | <p>The interRAI assessment has become the main tool used by the RNs and reassessment is carried out six monthly. The RN guide provided evidence that all residents' interRAI assessments were current. The review leads to the updating, where appropriate, of the VCare long term care plan and lists personalised goals. Usually three or more goals are listed, some of these are prepopulated and some have additional individualised goals. The evaluation process showed a lack of detail that identified that the individualised goals were being evaluated and if they had been met. In general, the comments related to the interventions. There was no comment on nutritional goal for weight loss, or continence management being effective.</p> <p>Annual multidisciplinary formal reviews are to occur. The review forms contained details by RN, physiotherapy, occupational therapy and medical staff. There is also space for discussion with resident and their family members. Three resident's files reviewed did not have input from the resident and/or their family member documented. Two files reviewed did not have an annual multidisciplinary team review document present.</p> <p>Several short-term care plans were sighted in the files reviewed. Paper plans sighted in residents' files did not have the evaluation and resolution documented. Examples sighted were for a skin tear and another for inflammation of the arm. The progress notes identified that these issues had been resolved.</p> | <p>Not all evaluations indicate the degree of achievement or response to the interventions being provided. For example:</p> <ul style="list-style-type: none"> - Not all goals were evaluated. - Not all MDT reviews are occurring annually. - An issue identified by the physiotherapist evaluation was not transferred into other areas of service delivery documentation. - Paper based short term care plans were sighted, for example, skin tear and inflammation of the arm. The progress notes identified that these issues had been | <p>The process of evaluation is all encompassing to include the resident's goals, and any issues identified by the multidisciplinary team. Documentation on the short-term care plans include review and closure. Annual formal reviews are completed and include comments from residents and family members.</p> <p>180 days</p> |

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| | | <p>A further resident's file showed the physiotherapy staff documenting a neck strain issue and a plan of action, plus resolution. However, there is no documentation in the resident's progress notes or evaluation documentation of this event.</p> | <p>resolved but the short-term care plan did not state the resolution.</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 |
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| Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate. | CI | <p>A person is employed to lead a team that is responsible for maintaining and further developing community partnerships that are consistent with the Eden Alternative, as a quality improvement initiative. The level of implementation of this philosophy is significantly enhancing the lives of the residents and is occurring at a level of continuous improvement.</p> <p>The team has defined communities as immediate and broader and now also refers to global communities. Reference was made to the process of enlarging circles within their immediate community of the home, whereby residents are taught to support each other and identify skills and knowledge that they can share with others. An example of this was a resident with minimal English language having taught and still teaching other residents, staff and volunteers how to play Mah-jong. Outcomes of a resident survey were analysed with a community perspective in mind with an example of classical music being identified by some residents as something they enjoy. Links have subsequently been made with the University of Auckland Music Department whose musicians are now visiting and even volunteering and support is being given to students from the residents. There are strong relationships with at least eight local schools and churches. Residents are</p> | <p>Creative and innovative approaches are being taken at an extraordinary level to strengthen residents' access to community leisure and lifestyle options and resources, to develop partnerships with a wide range of community groups and services across generations, and to bring the wider community into the facility. Such approaches are enabling residents to remain connected, enhancing their lives and preventing loneliness, boredom and helplessness, as per the expectations of the Eden</p> |

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| | | <p>becoming local community volunteers by teaching reading to children at the local schools, they have trained as ESOL tutors and are teaching the English language at churches and the local library is using residents with specialist knowledge such as beekeeping to give talks.</p> <p>Staff at Elizabeth Knox have facilitated residents' involvement in fundraising, not just by collecting on behalf of charities and schools but by creating items to sell on behalf. Letters of appreciation were sighted. A community partnership has been developed with 'Connect the Dots', which is an organisation aiming to connect older people and art. Residents who want to be attending monthly workshops and are involved in art appreciation workshops and then having a guided experience. Links have been made with the University of the Third Age for some residents who are attending special interest groups, and some have been further involved. A team of 700 to 800 volunteers contribute towards making these community links work and many will visit the facility and assist with resident led activities, whilst sharing some of their lives with them. At a global level, the team described the range of ethnicities among their volunteers and described their link with Denmark in that a student from there and spends three months working at the facility. Residents hear about the culture and relationships are maintained both ways once the student returns home.</p> <p>The range of community links makes a vital contribution to the leisure and lifestyle/activities as described in standard 1.3.7, although goes beyond just occupying the residents. Resident survey results identified the value of the community partnerships and the leisure and lifestyle team described how one improvement had led to new opportunities within the wider communities. There was good evidence of the uptake and development of these opportunities.</p> | Alternative. |
| <p>Criterion 1.1.6.2</p> <p>The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual</p> | CI | <p>During conversations with residents and family members, it became apparent that a strength of the service is the way individual values and beliefs are recognised and respected. Following further investigation, this was further validated by feedback in resident surveys, both general and activity related, and in staff interviews, especially with the leisure and lifestyle team.</p> <p>On admission, residents complete a document called 'Who I am' and information obtained from this contributes to planning the leisure and lifestyle plan for each resident as an individual, albeit some parts may be undertaken within a group of people with similar preferences. The values of the Elizabeth Knox Home and Hospital sit within the principles of the Eden Alternative, which places considerable</p> | <p>In response to a range of formal and informal feedback processes, there have been conscious efforts to improve the level of awareness of residents' individual needs and requirements around their ethnic, cultural, spiritual values and beliefs. Consequently, there has been a commendable increase in the opportunities</p> |

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| <p>values and beliefs.</p> | | <p>focus on recognising and supporting ethnic, cultural, spiritual values, and beliefs of residents. This process is occurring above and beyond that usually available to people receiving residential care and continues to develop further as residents become increasingly involved and are offered new opportunities.</p> <p>Examples to validate such statements include how through 2016 and 2017 there were monthly cultural celebrations within the facility, where groups of residents, their family/whanau, staff and volunteers met to celebrate different cultures, sharing the language, dance, food and traditions with everyone. The feedback was positive about the learning from each celebration but also the appreciation form those whose culture was being celebrated. A formal evaluation was completed, and the programme is being continued in a modified and more individualised manner. However, the service provider has continued, in partnership with residents, to host events and activities around dates such as Chinese New Year, St Patricks Day and Diawali festival, for example. Residents, volunteers and external cultural groups are involved in the preparations and celebrations.</p> <p>The catering service ensures a large range of vegetarian options and dishes from a range of cultures are always available and not only did the menu confirm this, but the dietitian acknowledged it. Halal meat is available on request and all food provided at the Children’s Christmas party was Halal. Additional cultural dishes are made available during cultural celebrations such as Chinese New Year.</p> <p>An interdenominational group meets weekly as a Christian Fellowship. The leader described how this has grown from a small group to a very large one and noted that although the structure and purpose has not changed, its delivery may alter according to the preferences of the residents at a given time. Specific faiths are accommodated with fortnightly visits from the Roman Catholic fraternity and monthly visits from a local Christian centre. An Anglican church across the road from the facility has strong ties to the service with a significant group of residents attending the services. Due to the growing demand for attendance and involvement, volunteers are being rostered to prepare and escort residents.</p> <p>Other sensitive activities associated with values and beliefs is when a person dies and the way the service provider and other residents farewell them. Email feedback from a funeral director described this process in detail and noted their own reaction to this. All rooms are blessed when a person leaves the service.</p> <p>Of note is that these activities are progressively developing in response not only to formal evaluation and survey responses, but also to informal positive feedback, increased attendances at opportunities, reports of appreciation, residents’ requests,</p> | <p>available to residents to celebrate and recognise these, and to improve their access to both internal initiatives and external services.</p> |
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| | | community support and volunteer input. | |
| <p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p> | CI | <p>In 2016, there were multiple complaints about the meals within this facility. Actions taken to address the issues raised have resulted in evidence of continuous improvement now occurring for this criterion. Verification was supplied during interviews, including with the chef and a manager from the catering company, minutes from meetings with a resident driven 'Food for Thought' group, a dietitian report, resident and family interviews, food satisfaction surveys, staff interviews and observations made during the audit.</p> <p>In addition to a registered dietitian reviewing the menus, the service provider is going to additional lengths to ensure nutritional requirements and personal food preferences are met, the food is of a high quality and that choices are available for residents. The dietitian noted in the report that 'admirable vegetable choices with very attractive salads' are offered and that varying cultural preferences are available. There are four options available for the main meal that is provided at mid-day and two for the evening. The menu has a vegetarian option and at least one option that reflected the multi-cultural population within the facility. Individual needs for modified diets or altered food consistencies are recorded and even those on soft, or puree diets have these creatively presented on the plate.</p> <p>An external catering service now operates within the facility. There was evidence of a committed lead cook who declared his main personal goal every day is to be assured all residents are happy with the food provided and that no-one is hungry. He is actively involved in ensuring residents food preferences and any specific needs are individually addressed.</p> <p>A 'by resident, for resident' group called 'Food for Thought' has been established and continues to operate under its terms of reference. Minutes of regular meetings show the resident voice is recorded, both individually and collectively, and passed onto the cook, or other relevant staff. Positive responses to the resident feedback were apparent. A 'learning circle' approach is used to obtain residents' views.</p> <p>Staff become trained as meal coaches and the learning package sighted showed they are taught attention to detail in relation to pre-meal preparation (the focus is the dining room), food serving and eating, finishing and cleaning and a key message is leading by example. Observations made at meal times showed that these principles are being upheld and that the cook personally approaches each table and talks to individual residents to ascertain their level of satisfaction and/or</p> | <p>Food services are operating at a level of continuous improvement as there is ongoing monitoring via a range of methods to ensure that personal preferences are honoured, that individual nutritional needs of residents are being met, the quality of food/meals is high, food is well presented and that residents can have a choice, as they would in their own home.</p> |

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| | | <p>their willingness to eat. Any issues of concern that were observed or reported were addressed immediately.</p> <p>Over the past two years, the number of food related complaints has reduced from, 62 to five. This has been attributed to the range of corrective actions taken, including those in relation to the quality and variety of food, number of options available, the dining room set-up, individual considerations and resident input. During interviews with residents and family members there was unsolicited feedback about the positive changes made, the excellent quality and quantity of the food and the patience of staff when assisting people with their meals.</p> | |
| <p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p> | CI | <p>There are principles of the Eden Alternative, which enables the service to strive for excellence around occupying residents. Key to these is the belief that loneliness, helplessness and boredom account for the bulk of the suffering among our Elders. Therefore companionship, creating human habitats that include ongoing contact with animals and children and integration within communities are keys to promote health and wellbeing. The service provider's commitment to implementing the principles of the Eden Alternative is demonstrating continuous improvement for this standard.</p> <p>Residents and family members spoke positively about the number and variety of leisure and lifestyle opportunities made available both within and outside of the structured monthly activity programme. Although the overall programme is coordinated internally, there was significant external community involvement over and above expectations. On one of the days of audit the range of options was evident with high school pupils assisting two groups of residents to play games such as Rummikub, an older resident was assisting other residents to play Mah-Jong, sit dancing had been observed and a local school choir had visited and sung to the residents. In the background residents were talking and working in raised vegetable gardens, finger nail painting was occurring, and a group of others were out in the facility van. Other residents were out individually pursuing personal interests or assisting in the community.</p> <p>Staff informed that participation in the leisure and lifestyle programme is considered part of their role, that a percentage of care partners are also allocated to assist with the programme and they described how they are actively involved. This was further evident in observations made throughout the audit. The team involved in leisure and lifestyle were interviewed during the audit. They demonstrated dynamism and</p> | <p>Formal and informal feedback processes in place inform that the diversity of meaningful leisure and lifestyle activities, which residents have access to, is exceptional, is enabling skills to be maintained and further developed within the limitations of individual capacities and is consistent with the principles of the Eden Alternative the service follows.</p> |

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| | | <p>creativity as they discussed not only what is currently happening but where they want to take leisure and lifestyle at Elizabeth Knox Home and Hospital going forward.</p> <p>Efforts are made to use and involve the 700 plus volunteers available from the wider community, there is a focus on normalising daily leisure and recreation throughout the day, rather than just occupying residents for a few hours a day, and there are genuine efforts made to ensure the residents' voices and preferences are heard. Creative ways are considered to meet preferences and to maintain community integrations as far as possible.</p> <p>Residents' levels of uptake and/or participation is monitored through informal feedback from residents following something they have done, or a place they have gone to, and evaluations and surveys are continually being used to monitor the options available. Resident and family satisfaction surveys demonstrated overall satisfaction with the programme and residents interviewed confirmed they find the programme stimulating and that there is always 'something' to do 'somewhere'.</p> <p>Results of a resident activity survey undertaken with a sample of residents in 2017 identified activities to keep in the diary and others to be added to the diary. The selection covers physical, cognitive, social and cultural aspects of options with a good focus internet/technical support, book club and games, on music and art, and on dancing and outdoor activities for example. Other feedback mechanisms, such as for culture and community participation, contribute to the activities within the leisure and lifestyle programme.</p> | |
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End of the report.