

Knox Home Trust - 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:

Legal entity:	Knox Home Trust
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: 29 March 2021 End date: 31 March 2021
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	205

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Elizabeth Knox Home and Hospital provides services for up to 213 residents. The service is operated by the Elizabeth Knox Home and Hospital Trust Board who employ a chief executive officer (CEO). The CEO has a small management team that provides clinical, financial and management support. The facility is located in Auckland on a single campus and a large campus redevelopment project is underway. Residents and families spoke very positively about the care provided.

The certification audit was conducted against the Health and Disability Services Standard. The audit process included the review of policies and procedures, the review of resident and staff files, observations, interviews with residents, family, management and staff.

The audit has resulted in a continuous improvement rating in areas of good practice, medicine management, food, fluid and nutrition and restraint minimisation. There were no areas identified as requiring improvement.

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 on display throughout the facility and information about rights is provided to residents and family members. Staff uphold residents' rights by demonstrating respect and providing services in a manner that supports personal privacy, independence, individuality and dignity.

A kaiāwhina is supporting the service provider to establish stronger links with tangata whenua and assisting residents who identify as Māori to have their needs met in a manner that respects their cultural values and beliefs.

There is zero tolerance of abuse, neglect or discrimination. Communication between staff, residents and families is open and confirmed to be effective. Access to interpreting services is available when required. Staff provide residents and families with the information they need to make informed choices and give consent.

The service has linkages with a range of community and specialist health care providers to support best practice and meet resident's needs.

Implemented good practices are a strong feature of the service.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

The business and quality and risk management plans identify the scope, direction, goals, values and mission statement of the organisation. The board receives adequate information to inform decision making. The organisation is led by a qualified manager.

The quality and risk management system includes collection and analysis of data and identification of trends that lead to improvements. Staff and residents provide feedback. Adverse events are documented with corrective actions implemented. Policies and procedures support service delivery and these were current and reviewed regularly.

Residents' information is accurately recorded in electronic systems, and only accessible to authorised personnel. Records are up to date and relevant. A very small number of documents are maintained in hard copy. Medicine management records are held within an electronic system.

The appointment, orientation and management of staff is based on current good practice. Training needs are identified and supported by the organisation. Each staff member has an annual performance review. Staffing levels and skill mix meet the changing needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standards applicable to this service fully attained.

The multidisciplinary team, including registered nurses, general practitioners and a nurse practitioner and the allied health team, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information, including

interRAI, and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are appropriately referred or transferred to other health services as required.

A diverse range of age appropriate activities are offered according to resident's personal preferences. Community participation is strong.

Medicines are safely managed in an electronic system and managed and administered by staff who are competent to do so.

Nutritional needs are assessed and personal food preferences and any dietary requirements are taken into account. Food management practices are regularly monitored and are safe.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Elizabeth Knox Home and Hospital is a compact campus which meets the needs of residents. It is clean and well maintained. There is a current building warrant of fitness and electrical and biomedical equipment is tested and checked as required.

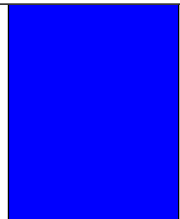
There are multiple communal spaces and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are practiced six monthly. Residents reported a timely staff response to call bells.

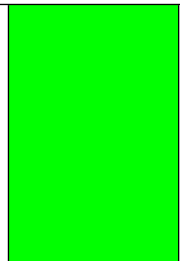
Security is maintained.

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.		All standards applicable to this service fully attained with some standards exceeded.
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Policies and procedures on restraint minimisation and safe practice not only support the minimisation of restraint but guide staff in the use of restraints and enablers. Use of enablers is voluntary for the safety of residents in response to individual requests. Comprehensive assessment, approval and monitoring process with regular reviews are occurring for all restraint use. Staff are supported by a designated restraint coordinator and those interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, is designed to prevent, and manage infections in the facility. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education. Covid-19 requirements were well managed, with a summary report made available to the Board.

Aged care specific infection surveillance is undertaken and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	48	0	0	0	0	0
Criteria	4	97	0	0	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Policies, procedures and processes are consistent with the Code of Health and Disability Services Consumers' Rights (the Code). Staff 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. Ongoing staff training on residents' rights is provided annually, as was verified in training records and during interview with the education and quality coordinator who noted the most recent session was at the end of 2020. The consumer auditor for young people with physical disabilities (YPD) interviewed 15 residents, of which six were under the YPD contract.</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 and give</p>	FA	<p>Informed consent policies and procedures and associated forms are available and provide guidance to staff. Completed informed consent forms were in the hard copy versions of residents' clinical records in the offices of each home. Copies of advance care plans and instructions for resuscitation also sit within these individual folders. Nursing and care staff interviewed understood the principles and practice of consent processes, including informed consent. Enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care and copies of separate signed consent forms for restraint and for influenza vaccinations were also in residents' files.</p>

informed consent.		
<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>Information about the advocacy services is available in policy documentation and in brochures. This includes the right for people to have a support person of their choice in a range of situations. During the admission process, residents are given a copy of the Code, which includes information on the advocacy service. Posters and brochures related to the advocacy service were on display and brochures are available from the offices in each home within the facility. Staff are provided with education on its availability and how to access it during their orientation and during annual staff training on residents' rights.</p> <p>Family members and residents spoken with were aware of the advocacy service and how to access this. A manager provided several examples of the involvement of different people operating as an advocate in relation to addressing concerns raised by residents. These included the kaiāwhina, Citizens' Advice, Age Concern, the Marist Brothers and the pastoral care team. Staff also have access to an independent support person.</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>	FA	<p>As mentioned above, the facility supports the philosophy of the Eden Alternative which identifies the three plagues of loneliness, helplessness and boredom as being accountable for the bulk of suffering among older adults. Hence, residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Transport is organised, as is accompaniment by a volunteer or family member when needed.</p> <p>The facility visiting times are now 10am – 11:30am and 2pm – 8pm. Dining rooms remain “visitor-free” from 11:30am to 2pm as it enables visitor free lunch and a quiet time for rest. A resident wanting a visitor during this timeframe needs to meet the person in their room. This decision is resident driven as they requested this in feedback following the 2020 lockdown due to the Covid-19 pandemic.</p> <p>Family members interviewed stated they always feel welcome when they visit and are comfortable in their dealings with staff.</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>There is a complaints policy which complies with Right 10 of the Code. On admission, information on the complaints process is given to residents and family members. Residents and family interviewed understood the process.</p> <p>A total of 10 complaints have been received in the last 12 months. A review of the register and files showed all investigation processes complied with policy and complaints were closed.</p>

		<p>The chief executive is responsible for managing complaints and reports one notification was made to the Health and Disability Commissioner. It relates to family not being able to visit a resident during level 4 Lockdown for Covid-19. The Health and Disability Commissioner declined to proceed with the complaint.</p> <p>There have been no complaints from external services since the last audit. Staff interviewed understood the complaints process.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through residents' meetings, in response to questions and when they entered the service, which was confirmed by family members during interview. An information package as provided to people on admission was viewed and included a copy of the Code and information on advocacy services and on how to make a complaint. The Code is displayed on the wall near the entry of each of the homes. Brochures on the Code are available in the office of each home alongside information on advocacy services, how to make a complaint and feedback forms.</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>	FA	<p>Residents informed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices, which was confirmed by family members interviewed and in residents' records reviewed.</p> <p>All residents have a private room or share a room with their partner. Staff demonstrated their awareness of residents' right to privacy and informed they are reminded of the importance of privacy and confidentiality during education on residents' rights.</p> <p>A strength of Elizabeth Knox rest home and hospital is its adoption of the Eden Alternative philosophy, of which the core concept is that 'care environments are habitats for human beings that should promote health, wellbeing and growth'. This supports residents to maintain their independence by choosing where they want to go and what they want to do and staff implement strategies for the choices to become reality. Residents attend community groups as per their personal choice and use their skills to assist others such as teaching English and supporting children with their reading. Many come and go as they please so long as they sign in and out. Care plans included documentation related to each resident's abilities, and strategies to maximise independence.</p> <p>Each resident's individual cultural, religious and social needs, values and beliefs are identified, documented and incorporated into their care plan. Examples of these were evident in initial care plans 'Who I am', 90-day care plans and long term care plans.</p> <p>Policies and procedures on abuse and neglect include definitions and actions to take in the event of such behaviours. Personnel files confirmed that staff education on the policy and procedures on abuse and</p>

		neglect occurs during orientation and annually. Staff understood the service provider's policy on abuse and neglect, including what to do should there be any signs. Reports of unacceptable actions had been taken seriously and confirmed management's declaration of a zero tolerance.
<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>	FA	<p>A current Māori health plan has been developed with input from cultural advisers and is a key document of the service provider. The Board of Trustees and the management team are committed to honouring the Treaty of Waitangi/Te Tiriti o Waitangi. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau. A kaiāwhina who is also a care guide, ensures Māori values and beliefs are integrated into the operations of the organisation and into the care and support provided. With links to Te Wānanga o Aotearoa and to Ngāti Whātua-o-Ōrākei, this person is taking the organisation, especially those who identify as Māori, on a spiritual journey whilst staying connected with the whenua. The kaiāwhina is supported by the registered nurses, staff who identify as Māori and the managers to integrate Māori cultural values and beliefs throughout the organisation and to provide guidance on tikanga best practice. Māori residents interviewed reported that staff acknowledge and respect their individual cultural needs.</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>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed with examples being the request to attend Mass, or other church services, maintaining links with family, sports (watching and participating), opera and poetry, and animals and pets. Additional support is available through a pastoral care worker who visits regularly, links with the Marist brothers, the kaiāwhina, a weekly fellowship group and a church across the road from the facility.</p> <p>A resident feedback document and a lifestyle, leisure and volunteering survey, both of which were completed within the last 12 months, confirmed that individual needs and personal preferences are being met. Family members believed their relative's cultural values and beliefs are both respected and supported.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff, residents and family members interviewed all informed that residents were free from any type of discrimination, harassment or exploitation. Residents said they feel safe and are well looked after. New staff are provided with the Code of Conduct and their induction includes education related to professional boundaries, expected behaviours and the Code of Conduct. Policies and procedures described actions to take should any form of exploitation be suspected, and managers described a zero tolerance of such behaviours from staff or volunteers.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from allied health professionals and external specialist services such as Mercy Hospice palliative care team, and education of staff. The general practitioner (GP) and nurse practitioner (NP) confirmed the service sought prompt and appropriate intervention when required and were responsive to medical team requests. Staff were described as being clinically astute and providing a high level of care.</p> <p>Nursing and allied health staff interviewed were able to describe how there is a focus on evidence-based practice and improving outcomes for residents. There are a significant number of clinical improvement activities which reflects an ongoing commitment to good practice, with strong leadership support for external education and access to professional networks to support contemporary good practice.</p> <p>A number of initiatives reflected an evidence-based practice approach. A project framework linked to the relevant Eden Alternative principles uses a “growth” analogy. It reflects sound preparation, identification of resource needs, information, the planned improvement process, and monitoring and evaluation processes involved. Timeframes for the project are realistic to capture the data and analyse it. Four of these initiatives will come together mid-year and will be reviewed and reported individually and collectively, to improve and integrate any improvement gains.</p> <p>The extensive and ongoing approach to continuous improvement in care delivery is evident across the organisation.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective 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 a family communication recording sheet in residents’ records reviewed. Registered nurses interviewed understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. The kaiāwhina is involved with whānau as applicable.</p> <p>Staff know how to access interpreter services through the local District Health Board when formal interpreter services are required. Staff have been used to assist with the informal communication with some residents and family members and family members have assisted their relative at different times with a number of examples provided. The policy and procedures describe situations such as for obtaining consent when a formal interpreter service needs to be used. Some basic signs, electronic systems, hearing aids and large print are examples of techniques in use to address potential communication shortcomings.</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 Trust Board meets monthly. It has four sub committees. Minutes and agendas reviewed showed they receive comprehensive information to inform decision making.</p> <p>The Board has adopted the Eden Alternative international practice model and has been rated at the highest level in 2015. The organisation was awarded The Auckland Chamber of Commerce Westpac Business Awards “Employer of the Year” in 2020 and ‘Excellence in Community Contribution’ in 2019.</p> <p>The strategic and business plan are reviewed annually and goals updated. The Board in 2021 completed a review of values. A group comprising board members and residents worked on this project jointly; each party expressed satisfaction at the outcomes. Staff have been educated on the new values and they are now implemented.</p> <p>The service holds contracts with the Auckland DHB, Ministry of Health and ACC for long term hospital and long term care for older people, residential care for younger people with physical disabilities, respite care and long term palliative care. On day one of the survey there were 205 residents, 144 hospital level care, 38 rest home care and 23 young physically disabled.</p> <p>The chief executive holds health professional and business qualifications and has been in the role for 13 years. There is current job description and a delegations of authority policy.</p>
<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>In the absence of the chief executive, required duties and responsibilities are undertaken under delegated authorities by the commercial manager (finance), the care leader (clinical) and the project support manager (management). Staff reported they are informed when the delegations are in place.</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</p>	<p>FA</p>	<p>The organisation has a well-established quality and risk system that reflects the principles of continuous quality improvement. There are clear linkages between quality and risk systems with outcomes for achievement identified. There is management and monitoring of adverse events and complaints, audit activity, satisfaction surveys, outcomes and interventions. This is overseen by management and the Quality Committee. Meeting minutes confirmed regular review and analysis of quality indicators. Elizabeth Knox contributes to an external benchmarking database. This benchmarked data is reported</p>

<p>reflects continuous quality improvement principles.</p>		<p>throughout the organisation.</p> <p>Fifteen methods of monitoring quality are undertaken with corrective and improvement activities identified. Examples include the falls project underway and the evaluation and update of training which has been completed and implemented. Early feedback on the changed training programme is positive. (Refer also Standard 1.1.8) Staff indicated they are involved in audit activity and change projects.</p> <p>Resident and family feedback is sought through meetings and area/topic specific surveys. Satisfaction is overwhelmingly positive.</p> <p>Policies reviewed cover all necessary aspects of service. Policies are based on good practice and were current. The document control system ensures a systematic and regular review process, which staff confirmed they are involved in. Policies are held electronically, and obsolete documents are retained.</p> <p>The risk register is monitored by the board and management. All risks are rated and have mitigation strategies.</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>	<p>FA</p>	<p>Staff document incidents and near miss events on an incident form or electronically. A register of events is maintained and a review of 10 incidents showed these were completely investigated and action plans implemented if required. A comprehensive review of 12 months of incidents showed four recommendations for improvement and these have been implemented.</p> <p>The chief executive is responsible for and understands essential notification requirements. There have been no notifications since the last survey.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies related to human resources are in a manual and employment processes are based on good employment and legislation. Pre-employment processes include referee checks, police vetting, immigration clearance, validation of qualifications, and where applicable, annual practising certificates. All interview panels at Elizabeth Knox have a resident interviewer. A sample of staff records were reviewed, and appropriate records are maintained. All nurses, allied health professional and doctors have current practising certificates.</p> <p>A review of the training records shows all mandatory training has been completed and professional development particularly relating to younger people with disabilities has been undertaken. Staff interviewed confirm training has occurred.</p> <p>A comprehensive orientation is undertaken which includes all mandatory and role specific training. Staff</p>

		<p>interviewed commented that the orientation was very helpful in preparing them for their role. A copy of the completed orientation is kept on file and showed a performance review after three months.</p> <p>A learning needs analysis was completed in 2020 and the annual training calendar was updated. All care partners are encouraged to undertake New Zealand Qualifications Authority education while registered nurses are underway with development of Professional Development and Recognition Programme (PDRP) requirements. There are 37 registered nurses and 17 are trained to undertake interRAI assessments. Personnel files reviewed showed annual appraisals and the appraisal register shows all staff have had a review within the last 12 months.</p> <p>In 2020, the organisation established a medical practice which has, on average, four doctors. The practice is a member of the Auckland PHO.</p> <p>There are between 80 and 100 volunteers. Their recruitment processes are similar to employees. The volunteers work approximately one to three hours per week with the leisure and lifestyle team.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is policy outlining minimum safe staffing levels and skill mixes to meet residents' needs, 24 hours a day seven days a week. Staffing levels are adjusted and meet the changing needs of residents. Staff interviewed state they have adequate time to complete their work while family and residents stated there was enough staff available to meet their needs.</p> <p>There is a registered nurse on duty 24 hours a day in each of the homes (20 to 25 residents per home). In addition, there are four to five care partners on duty on afternoons and two overnight. Replacements are made for planned and unplanned absences/leave. At least one trained first aider is on duty at all times.</p> <p>A review of the last four weeks of rosters showed the required staff were on duty. Staff interviewed confirmed these numbers. A general practitioner is on call 24 hours a day and a nurse practitioner supports the clinical leader.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the electronic resident files sampled. Clinical notes were current, comprehensive, and integrated with allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. All resident records reviewed contained the resident's unique identifier (NHI). Records were legible with the name and designation of the person making the entry identifiable. Medical records from the linked Knox medical practice are available, with the consult detail pasted into the electronic patient management system.</p>

		Archived records are held securely, with increasing use of scanned records for more recent and current residents. Records are readily retrievable. No personal or private resident information was on public display during the audit.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Admissions are undertaken with the assistance of the care administrator who provides pre-admission tours of the facility and an information package. Copies of information about the Eden Alternative, copies of the KnoxLife newsletter and annual reports complement information about the services provided. Residents require an assessment by the local Needs Assessment and Service Coordination (NASC) service prior to entry to ensure they meet the scope of services provided. The care leader makes the final decision, although this may involve consultation with the allied health team. Admission processes are undertaken by the care administrator and the care leader, who may seek additional information as required. The organisation seeks updated information from the GP for residents accessing respite care.</p> <p>Family members 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. Signed admission agreements reviewed had been completed within required timeframes. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort provided if required.</p> <p>The service uses the "envelope" system to facilitate transfer of resident information to and from acute care services. This requires any necessary information including care plans, essential contact information and medicines detail to be printed and sent with the resident. Medical information may be sent from the practice software. There is open communication between services, the resident and the family/whānau, with staff reporting they keep up to date with residents transferred to acute services. At the time of transition between Elizabeth Knox and other residential facilities, appropriate information is provided for the ongoing management of the resident.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that</p>	FA	<p>A current medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the days of audit. Thirty electronic residents' records were reviewed across all homes in the facility. The staff observed</p>

<p>complies with current legislative requirements and safe practice guidelines.</p>		<p>demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage with demonstration of competency requirements necessary on an annual basis. Registered staff are also trained and competent in the administration of subcutaneous medications via syringe drivers, although none were in use on the days of audit.</p> <p>Medications are supplied to the facility in a pre-packaged (robotic packaging) format from a local contracted pharmacy. The registered nurse in each home checks medications against the prescription and records reconciliation on the electronic system. Some homes have an individualised storage and administration system (locked cupboards in the room) with medicines administered by care partners, while other homes undertake a medication “round” undertaken by a registered nurse.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The need for double signing is alerted to staff in the electronic system. All non-packaged medications sighted were within current use by dates. Clinical pharmacist input is readily accessible, including assistance with six monthly checks of the controlled drug registers, which include recording the required quantity stock counts and weekly physical stock takes. The records of temperatures for the medicine fridges were noted to be within the recommended range.</p> <p>Prescribing practices included the prescriber’s electronic signature and date recorded on the commencement and discontinuation of medicines. All requirements for pro re nata (PRN) medicines includes maximum dose in 24 hours, rationale for use and recording of effectiveness are included. In spite of appropriate prescribing of PRN medicines, there is low usage noted. Where regular use does develop, then changes are made to incorporate this as part of regular administration. The required three-monthly GP reviews are consistently recorded on the medicine chart. Standing orders are not used. Allergies and sensitivities are clearly recorded on the resident’s file and on their medication chart. Cautionary advice is included on the charts where appropriate and alerts for same/similar names is clearly noted.</p> <p>One resident was self-administering their oral medications (except for a variable dose anticoagulant), with documented assessment/reassessment and a signed agreement in place. Medication was stored safely in the resident’s room. Other residents may self-administer inhalers if considered competent. Appropriate processes were in place to ensure this was managed in a safe manner and the registered nurse and resident interviewed could describe the processes to be followed.</p> <p>There is an implemented process for reporting of any medication errors. Review of records confirmed this process is followed, medication errors are investigated and there is follow up with staff involved. There are notably few errors recorded.</p> <p>A continuous improvement rating has been awarded for the outcomes associated with the polypharmacy project (see 1.3.12.1).</p>
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<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by an external contractor, which supplies qualified chefs and a kitchen team. Separate summer and winter menu options follow a six weekly rotational cycle and are in line with recognised nutritional guidelines for older people. The current summer menu was reviewed by a qualified dietitian 16 November 2020. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food control plan 1 January 2021 and registration by an audit agency on behalf of the Ministry of Primary Industries. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Continuous quality improvement processes that are based on resident focused approaches are being used to ensure the meals not only meet the needs of residents but meet personal preferences. A continuous improvement rating acknowledges the ongoing and developing efforts being made to sustain this, which is having positive outcomes for residents.</p>
<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 managers noted that the Elizabeth Knox Home and Hospital has a philosophy of integration of all interests and the inclusion of all ages and abilities, which means that it is rare for a person to be declined entry so long as they meet the criteria. If a referral is received by a person who does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. Two examples of prospective residents for whom Elizabeth Knox Home and Hospital did not have the appropriate resources to care for were discussed.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated. There is currently a short waiting list of people specifically wanting rest home level care rooms.</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 fully documented based on validated assessment and interRAI tools used to inform care planning. Care plans are based on the assessed needs and included outcome goals and interventions which included the resident's wishes and preferences. The sample of assessments reviewed provided an integrated range of resident-related information. All residents have current interRAI assessments completed including a small number scheduled to occur in the current month. Relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process shortly after admission and reassessments when needs change.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>All plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process plus any other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. This included recognition of the special relationship of a married couple together in care.</p> <p>A recent introduction of a wall plan titled "My 90-day plan" is being rolled out across the facility. It is resident driven wherever possible and enables personalised information to be entered on a wipeable board in the room. Residents are encouraged to write these themselves and describe their specific personal goals using "I" focussed statements such as:</p> <ul style="list-style-type: none"> - Everyday things that are important to me - My whānau and friends - My wellbeing will improve when I - I feel calm when..... <p>While this initiative is in the early stages, resident using it reported finding it helpful.</p> <p>Care plans evidenced service integration with progress notes, wellbeing and lifestyle and leisure notes. Medical and allied health professionals' notations are clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff including at handover. Residents and families reported participation in the development and ongoing evaluation of care plans. One family member expressed confidence in the plan of care developed with her input and commented that she could now "just be the daughter again" after a long period of caring for her parents.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate</p>	<p>FA</p>	<p>The Eden Alternative principle outline a philosophy aimed at eliminating loneliness, helplessness, and boredom in a caring, inclusive and vibrant community. Several residents interviewed discussed how their needs are being met in a supportive environment. Suitable documentation in the form of care plans,</p>

<p>and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>support the care provided to residents which is consistent with their needs and goals and their individual plan. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP and nurse practitioner interviewed, verified that medical input is sought in a timely and appropriate manner, that medical orders are followed, and care is of a high standard. Care staff interviewed described how they provide care as outlined in the documentation. A range of equipment and resources are available to support care delivery, suited to the levels of care provided and in accordance with the residents' needs.</p> <p>Individualisation of care was particularly evident for the young people with disabilities who come and go as they please within safety parameters applicable to each person (e.g., overnight stays with friends; taxi outings for shopping outings; attendance at regular clubs, cafes, restaurants, and entertainments such as shows and movies).</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The lifestyle and quality coordinator and the community partnerships coordinator work alongside leisure care partners to ensure the residents have access to meaningful engagement opportunities both on and off-site. A basic weekly activity diary over seven days is developed and available to all residents and residents can choose their level of participation. This is holistic in nature and includes options that vary from music, entertainment, games, spiritual fellowship, games, baking, movies, quizzes, crafts, and gardening, for example. In line with the Eden Alternative philosophy of sharing and growing, community partnerships have developed with local churches, a large community centre, local schools, the library, and a day care centre for example. Residents may take on leadership or learning roles in these settings with examples of residents reading to children, supporting them with learning to read and teaching English to people for whom English is a second language. A strong team of volunteers assist with the activities programme both within the facility and on trips elsewhere.</p> <p>A section of the electronic care planning system records individual goals and objectives in relation to activities and personal development for each resident. This is titled 'promoting wellbeing and reducing loneliness, helplessness and boredom', as per the three plagues of the Eden Alternative philosophy. All residents' files reviewed had this section completed. Progress notes for lifestyle and leisure are written into the reporting system weekly or when considered appropriate.</p> <p>An evaluation framework built into the electronic care planning system is used to evaluate progress every six months, and as needed. Reviews of residents' files confirmed this is occurring in a timely manner in the relevant section of the care plan. Additional platforms used to capture residents' interests is the 'Who am I?' document completed just prior to admission and the 90-day care plan, which is resident driven and gradually being implemented into residents' lives.</p> <p>Residents' preferences and evaluation of the activities available occur via regular residents' meetings, residents' surveys and one on one conversations with the leisure and lifestyle coordinator, or lifestyle</p>

		<p>care partners.</p> <p>Activities and outings for the YPD people are age appropriate, with encouragement to be as independent as they safely can be.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated on each shift and consistently reported in the progress notes. These provide a detailed evaluation of actions taken and progress towards individualised and personalised goals. If any change is noted by care partners, it is reported to the registered nurse who takes further actions or seeks suitable internal or external advice. An 'SBAR' communication tool is used to document any out of hours calls to medical staff, and these are reviewed to determine whether earlier intervention may have reduced the need for the call out. Any learning is shared.</p> <p>A 'residents-at-risk' meeting is held fortnightly to discuss and plan care for residents with changing or deteriorating conditions, or for whom staff have concerns. It is attended by registered nurses and the care leader. Minutes reviewed indicated timeframes and responsibilities for actions are identified. Case studies by staff from various homes are used as appropriate for greater organisational learning. Recent presentations include motor neurone disease, cerebral infarct, and a root cause analysis for aspiration pneumonia. On occasion, a mortality review has been undertaken and discussed at the meeting.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care as evidenced in a number of files reviewed. Examples of short-term care plans being updated, and progress evaluated as clinically indicated were noted for infections, wounds and following a fall. When necessary, and for unresolved problems, long term care plans are added to and updated ahead of a scheduled review. Documentation is a dynamic reflection of the care each resident requires. Residents and families interviewed provided examples of involvement in evaluation of progress and the effectiveness of any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And 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</p>	FA	<p>Residents are supported to access other health and/or disability service providers as needed or if they wish. Referrals are documented in the electronic record. Although the service has its own Knox medical practice, residents may choose to use another medical practitioner. The practice is able to refer to other primary, secondary, and tertiary services through the e-referral system. Evidence of referrals were sighted in residents' files for continence, oncology follow up, ophthalmology and diabetes management. An arrangement for referral for specialist input from Mercy Hospice is also in place and well used for the palliative stage of care. The resident and family/whānau are kept informed of the referral process, as verified in three files reviewed and from interviews.</p>

<p>choice/needs.</p>		<p>Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. However, the ready availability of medical support via the practice, both in and out of hours is also readily available. There is a system to ensure there is comprehensive resident information sent with the resident.</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>Policy on management of waste and hazardous substances guides staff. Waste is segregated at collection and stored and removed from the site in a timely manner. The only chemicals held are domestic cleaning products and these are stored in the locked cleaning cupboard.</p> <p>Safety datasheets are stored in the cleaning cupboards. Spill kits are readily accessible. Staff interviewed indicated that protective clothing and equipment was readily accessible and they were observed using these products.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The current building warrant of fitness is displayed in the foyer and expires on 28 September 2021.</p> <p>The testing and tagging of equipment is managed by the Elizabeth Knox maintenance team, while biomedical testing and calibration was last undertaken by an external contractor on 8 October 2020.</p> <p>The environment was hazard free, residents were safe and independence is promoted. External areas are safely maintained. Staff interviewed knew how to access maintenance services and residents indicated the environment was safe.</p> <p>There is currently preparation underway to demolish an aging building and build a new 60 bed facility.</p>
<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</p>	<p>FA</p>	<p>There are adequate numbers of bathroom and toilet facilities. The newer two homes have 85 ensuite rooms. The 'wet rooms' are large, have safety rails and a call bell. The remaining 128 rooms have shared facilities of one bathroom and toilet to two to three patients. The 'wet areas' have safety rails and call bells.</p> <p>Residents and family indicated these facilities meet their needs.</p>

hygiene requirements.		
<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>There are a range of room sizes with the bedrooms in newer parts of the campus being roomy and allowing ease of mobility and storage of aids. The smaller rooms are adequate with storage areas close to rooms.</p> <p>All residents have single bedrooms and indicated space is adequate. Residents' rooms have personal items of their choice.</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, and dining needs.</p>	FA	<p>Communal areas are available both internally and externally. Each home has at least two lounges (total 16) and dining rooms (total 17). Corridors are large and furniture is used to allow cluster groups. Families and residents commented that there is plenty of communal space.</p>
<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 by dedicated Elizabeth Knox staff. In addition, there is a domestic washer in each home for residents' selected washing.</p> <p>Nine staff work over a 12 hour period and in discussions were clear about processes and standards in relation to dirty/clean flow and handling of soiled linen. They participated last year in the updating of the laundry manual. There is quality control of laundry product by the team leader.</p> <p>Cleaning services are provided by an external company and there is a full-time manager on site. Staff receive training and were able to answer questions about use of product and cleaning procedures. Chemicals are stored in locked cleaning cupboards and all products were in manufacturer labelled containers. There is a cleaning audit performed every week.</p> <p>The facility was observed to be clean and smelled fresh. Residents and families agree the facility is always tidy and clean.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p>	FA	<p>Policies and procedures, together with flipcharts (displayed in offices), guide staff in management of emergencies and in the event of fire. Flooding is identified as the most likely natural disaster and an annual desktop exercise is undertaken. There is an approved evacuation plan which was signed off on 23 July 2019 and six-monthly fire drills are undertaken. The most recent in November 2020, had no</p>

<p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>recommendations.</p> <p>Fire safety training is undertaken at orientation with an annual update. Staff state they know what to do in an emergency.</p> <p>Adequate supplies of food are stored for a period of three days for the 205 residents. Water is collected in tanks on site and stored while a diesel generator ensures no loss of utilities. This generator is tested monthly.</p> <p>There is a silent call bell system with staff all carrying smart phones. Emergency calls are audible. Call bell activity is constantly monitored with monthly reports produced.</p> <p>Staff reported one security incident since last audit. An external security firm is contracted to check the premises at night and to lock windows and doors in the evening. Entry after 8pm is via intercom at the front door. Surveillance of both exterior and interior areas occurs. Residents and family are informed at admission.</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>	<p>FA</p>	<p>All residents' rooms are heated with radiators and have opening windows for ventilation. All bedrooms have opening windows and plenty of natural light. A small number of bedrooms have a door opening onto a terrace. Heat exchange systems operate in communal and corridor areas. Residents and family reported the temperature as comfortable.</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>	<p>FA</p>	<p>The service has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff, and visitors. The programme includes an operational plan signed off by the Board in January 2021. The programme is guided by a comprehensive and current infection control and surveillance policy and includes external benchmarking. Data is expressed as a percentage of the average daily occupancy.</p> <p>A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in policy. Infection control matters, including surveillance results, are reported monthly to the clinical service manager, and tabled at the quality, health and safety and IPC committee meeting. This committee includes the IPC nurse, care leader and representatives from each of the homes and support services. It meets bi-monthly and reports to the Elizabeth Knox quality meeting.</p> <p>The organisation is participating in a project in association with the Health Quality and Safety Commission (HQSC) to optimise the use of antibiotics in the management of urinary tract infections in</p>

		<p>aged care. The goal is a reduction in antibiotic prescriptions for residents whose symptoms do not meet the criteria for a urinary tract infection. A decision-making guide has been developed and implemented. The IPC nurse is engaged in this project and is collecting and reporting relevant data.</p> <p>A Covid-19 Risk Management Plan report (December 2020) has been presented to the Board, summarising the actions taken, their effectiveness and impact. It considered the suitability of the policy, staff compliance and the response of residents and whānau. The organisation was an early adopter of restrictions (ahead of the national lockdown), including visitors and volunteers. The response management team was headed by the CEO and the medical director. Daily meetings (Zoom) with a standing agenda were held seven days per week to monitor and prepare for an outbreak. Physical zones were established to restrict staff and resident movement, with two meal sessions and defined seating plans for meals. Some activities/services were limited or ceased for the duration. Any residents with respiratory symptoms were confined to their rooms and had a nasopharyngeal swab (n = 90). Auckland Regional Public Health were notified for all completed tests via Medtech. All residents were required to have a Covid-19 assessment form and short-term plan in the electronic management system while awaiting test results.</p> <p>Infection Prevention and Control (IPC) activities were also strengthened, such as hand washing, cleaning, and sanitising, PPE use and room isolation of residents with flu like symptoms. Very regular communication from the CEO including a dedicated 'News@Knox' account was available for residents, families, and staff to ensure current information was constantly available. An additional ten tablet devices were purchased so that residents could keep in touch with families during lockdown. A taonga in the form of a published booklet "A day on the life of Knox – Stories of Lockdown" was subsequently gifted to all residents and families. There was also careful monitoring of staff wellbeing. There is confidence in the established systems and processes for infection prevention in the facility in relation to Covid-19 and no cases linked to the service were recorded.</p> <p>As a result of the Covid-19 pandemic, extra signage and temperature checking occurs at the entrance to the facility and visitors are requested to wear masks.</p> <p>Staff are encouraged to have a seasonal flu vaccine, with the organisation well progressed with cold chain accreditation for the next vaccine roll out. There is clear guidance for staff about expectations for coming to work when unwell.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information</p>	<p>FA</p>	<p>The IPC coordinator has appropriate skills, knowledge, and qualifications for the role. The person is stepping aside; however, the role is being overseen by the care leader in the interim recruitment phase for an IPC qualified person. Both staff were interviewed as part of the audit.</p> <p>Staff also receive education in infection prevention and control, as verified in training records sighted.</p>

<p>resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>Additional support and information can be accessed from the infection control team at the DHB, the community laboratory, the Knox practice and public health unit, as required. The coordinator has access to residents' records and diagnostic results through the medical practice to ensure timely treatment and resolution of any infections. Medical staff are reported to be fully engaged with the infection control programme.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. PPE stocks, outbreak management signage and supplies were sighted during the audit. The service reports it has maintained good stocks of PPE on hand.</p>
<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>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies reviewed are current and include appropriate references. Information for staff on the prevention and management of Covid-19 has been prepared and communicated. A pathway "I think my resident may have a UTI" has been developed based on a UTI decision support algorithm adapted from a HQSC Frailty Guide.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and appropriate use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</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>	<p>FA</p>	<p>Interviews, observation, and documentation verified staff have received education on infection prevention and control at orientation and via ongoing education sessions. There is a focus on hand hygiene for all. Some education is provided online, and suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. A record of attendance is maintained.</p> <p>Additional education has occurred in preparation for the ongoing management of Covid-19 and a possible outbreak. This included donning and doffing of PPE, hand hygiene and information on the facility's pandemic plan, implementing home "zones" for residents and staff and outbreak management.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and isolation practices. Residents</p>

		were kept well informed by staff and the organisation during various lockdowns.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to the recommendations for long term care facilities. Requirements are documented in the updated surveillance policy. This includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, and the upper and lower respiratory tract. The IPC coordinator reviews all reported infections, and these are documented in the resident's electronic records. New infections and any required management plan are discussed at handover and documented in a short-term plan of care to ensure early intervention occurs. This was verified by observation, interview, and review of electronic residents' files.</p> <p>Monthly surveillance data is collated for each home and reported to the quality, and IPC meeting (bi-monthly). Data is reviewed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via meeting minutes. Graphs are produced that identify trends for the current year. Data has been collected since 2013 and is benchmarked externally through the external benchmarking programme. Benchmarking results (n = 256) across Australasia indicates an infection rate below the median for the sector. Work with HQSC in relation to identification and management of suspected urinary infections is seen as an opportunity to improve the organisation's results.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	CI	<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 provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, 15 residents were using restraints (14 safety belts and nine bedrails with some using more than one type). Twenty-five people were using one or more enablers with 21 of these being bedrails and 14 safety belts. Those using enablers were the least restrictive option and used voluntarily at their request with the person responsible for signing the relevant form. A similar monitoring and review process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on files reviewed, and from interview with staff, in particular the restraint coordinator. Records of the processes related to a project aimed at reducing the use of restraints at this facility were comprehensive and the achievements to date have meant a continuous improvement rating has been applied for this standard.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group, which is made up of all registered nurses who work at Elizabeth Knox home and hospital is responsible for the approval of the use of restraints and the restraint processes. It was evident from reports provided, and interviews with the restraint coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement and of medical consultation in the decision making was on file in each case. Use of a restraint or an enabler is integrated into 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>A registered nurse commences the consent and approval process for use of an enabler or a restraint. Assessments for the use of restraint were documented and included all requirements of the standard. Assessment processes identify the underlying cause, cultural considerations, alternatives tried or discussed and associated risks.</p> <p>The registered nurse/restraint coordinator noted that the desired outcome is always to ensure the resident's safety and security. This person described how one of the registered nurse team undertakes the initial assessment with their involvement. Input from the resident's family/whānau/EPOA is sought and this was evident on documentation sighted. A consent and authorisation form is completed. The general practitioner is involved in the final decision on the safety of the use of the restraint and signs the consent and authorisation form. Completed assessments were sighted in the records of residents who were using a restraint.</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 coordinator described how although alternatives to restraints are discussed with family members, there is often resistance to them being removed or reduced.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is available if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each registered nurse meeting, which operates as the restraint approval group. The register was reviewed and contained all residents currently using a restraint, or an enabler, and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's restraint minimisation and safe use policy and</p>

		procedures and in related topics, such as enabler use and positively supporting people with challenging behaviours.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during interRAI reviews and multi-disciplinary team care plan reviews. In addition, all restraint use is evaluated monthly at registered nurse meetings, which operates as the restraint approval group.</p> <p>The evaluation covers all requirements of the standard, including future options to eliminate use, the impact and outcomes achieved. As indicated in 2.1.1, this is an effective process in accounting for the reduction in restraint use. There was evidence in documents sighted that reviews included the level at which policy and procedures were followed and whether documentation was completed as required.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	<p>All restraint use is discussed at monthly registered nurse meetings. On behalf of the registered nurses, the restraint coordinator provides a restraint use report to the executive team who feeds the information through to the board. This requires the inclusion of reasons for each use of a restraint and why any use of restraints may increase.</p> <p>Similarly, the restraint coordinator provides a restraint report to the monthly care and quality meeting. This was confirmed in meeting minutes sighted, which included possible suggestions for alternative approaches for clinical review, evaluation reports on its use, the content of restraint / enabler education and any feedback from key stakeholders, including the doctor, staff and families. Six-monthly internal audit reports are fed back to the care and quality meetings.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Implemented evidence based practice is noted in a number of initiatives reviewed at audit. These include</p> <p>Wellness optimisation through falls prevention arose from analysis and trends from falls – with and without injury, over recent of years. In spite of positive benchmarking results, the organisation remained concerned that falls without injury were creeping upwards (based on 10 years of data). Two homes were selected to implement the project aimed at reducing the overall falls rate by 20% by June 2021. Interviews with the falls committee led by a physiotherapist indicated a breakdown of all falls (reports sighted) and the implementation of strategies including a thorough assessment, individualised care plans, use of hip protectors, prescribing Vitamin D therapy, suitable footwear, consideration of the environment, appropriate use of sensor mats and a programme of individual strength and balance interventions and group sessions scheduled for those at risk, or for frequent fallers. Early results indicate a reduction in the number and severity of falls since November 2020. Evaluation of the project continues till June, then roll out of the most effective interventions will occur across services.</p>	<p>The positive environment at Elizabeth Knox Home and Hospital actively supports sound, evidence-based practices, and a range of initiatives which benefits residents and staff wellbeing. The extensive and ongoing approach to continuous improvement in care delivery is evident across the organisation.</p>

	<p>Analysis of interRAI assessment data and an external benchmarking programme results over a three-year period has been used to provide the organisation with a consistent picture of resident health (more stable, less depression, less behavioural challenges) against national and international averages. Characteristics of the care were noted in the first quarter report of 2020 which reflects fewer falls with injury, fewer pressure areas, fewer wound and skin infections and less unplanned weight loss. Knox has ranked second lowest for falls with injury amongst contributing services in Australasia over the past five years and better than the benchmark for the other indicators.</p> <p>A “winter wellness” campaign followed lockdown. This involved a focus on “food”, “move” and “mood” – one item per month from June to August 2020. Participants included residents and staff in their bubbles. It combined fun, camaraderie, prizes, and health benefits, with a focus on healthy food – dishes were demonstrated and had to be recreated by participants; “move” which recorded steps on an app for an individual team, with a prize, and “mood”, with a focus on smoking cessation, Pilates, and yoga sessions. At least 30% of staff participated. Recommendations have been made to repeat the programme and achieve even greater engagement in 2021.</p> <p>A safe moving and handling programme was commenced in 2020 and aims to standardise staff training on moving and handling using best practice guidelines. Though delayed through Covid-19, it included analysis of moving and handling incidents attributed to inappropriate moving and handling. Staff have received a targeted refresher, competency assessment and new staff a more in-depth orientation on the topic. The programme resulted in a 12% reduction in reported events for the six months duration of the programme.</p> <p>Creation of community partnerships demonstrates good practice: Elizabeth Knox staff work alongside organisations including the local library, a large local community centre, a local church and schools, and a pre-school day care centre (a few examples only) to foster relationships between the residents at Elizabeth Knox and the wider Auckland community. The philosophy is for people from Elizabeth Knox to collaborate with community members by using their skills such as teaching English to migrants and supporting others such as children, to share these with the people at Elizabeth Knox. Volunteers actively assist with these programmes.</p> <p>Cultural diversity and a bicultural commitment: Although EKHH has demonstrated cultural awareness across cultures and celebrated ethnic differences for a number of years, the employment of a care guide, who has</p>	
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		<p>since become the organisation's kaiawhina is enabling staff and residents to explore cultural diversity and biculturalism even further. The Māori concepts of whanaungatanga, wairua and manakitanga, in particular, are being explored with staff and residents, external support is being brought in for people to learn Te Reo, and additional Māori staff have been employed. Although in the early stages these changes are embracing Māori culture and biculturalism, while at the same time allowing other people freedom within their own cultural norms.</p> <p>Workplans are developed for care partners, registered nurses, and care leaders for 2021. This includes examples such as promotion of continence and continence assessment, a handover project, Eden Alternative principles integrated into care planning, embedding of the professional development recognition programme (PDRP), a focus on clinical reasoning skills, expanding the medication optimisation programme (see 1.3.12) and development of a urinary tract infection pathway.</p>	
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	CI	<p>A medicines optimisation project undertaken in two homes in late 2020, reviewed data from a polypharmacy report generated from the electronic medicine management system and considered researched evidence that polypharmacy contributes to an increase in adverse drug events and medication errors. Data indicated that 68% and 78% of residents in these two areas were taking more than five regular medicines. The service identified that there was no consistently applied framework for a medication review process. The project sought to reduce any adverse effects of polypharmacy for residents and optimise medication use as part of the regular three-monthly medicines review.</p> <p>An evidence-based framework for the systematic review of medicines was developed and implemented for the 21 residents involved. Initially, a resident and family information session was provided by a pharmacist and also an outline of the project to prescribers. The 'ICARUS' grid was used as a tool for optimisation and a STOP and START review tool introduced. Excluded were nutritional supplements, creams, and PRN medicines. The clinical lead (doctor) supported its implementation and its alignment with the Eden Alternative model of care. Specific project time was allocated to facilitate data collection and analysis. The project resulted in 50% of residents having a number of medications reduced, removed (or started). Further medications are also being considered by prescribers for change at the next medication review. No residents were hospitalised due to deprescribing and residents, registered</p>	<p>A reduction in polypharmacy was evidenced for 10 of 21 residents taking more than five regular medicines has occurred as a result of the medication optimisation project. The process is now being extended to other homes in the service. This improvement project has benefitted residents and engaged the general practitioners in considering the impact of prescribing multiple medicines to frail and at-risk residents. The project demonstrated effective quality improvement processes and a continuous improvement approach.</p>

		nurses and the medical team all described benefits of the initiative. Going forward, the process will become embedded in the existing medical review process as a means to optimise use of appropriate medications for residents.	
<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>The team from the catering company described resident focused approaches to ensure the food supplied is not only nutritionally appropriate, but also meets the preferences of the residents at Elizabeth Knox Home and Hospital. Every three months a 'Food for Thought' group comprised of catering company staff, a resident representative and some care partners meet to discuss the level of satisfaction/dissatisfaction with meals and any preferred options. Once a year this group is extended to include a representative from each home.</p> <p>Feedback from the 'Food for Thought' group guides menu development, which occurs twice each year, once before the winter menu changes to summer and again when the summer menu changes to winter. All residents have two to three weeks to review each draft menu and a dietitian is involved in this process.</p> <p>A large, photocopied menu with four options for the main mid-day meal and two options for the lighter evening meal is taken to each person's room each day. Residents select their preferred options and at the same time have the opportunity to document any feedback about the previous day's meals for the chef. In addition, one of the kitchen team informally approaches residents after meals to ascertain the overall levels of satisfaction, which complements more formal feedback.</p> <p>Efforts have been made to enhance the dining experiences of residents. Post pandemic lockdown feedback processes provided information that residents appreciated quieter mealtimes and visitors are now asked not to visit during the mealtime, or to go to the person's room if they do so. Similarly, two sittings are managed to enable residents to have a less crowded and more relaxed dining experience.</p> <p>Attention to detail towards meeting residents' personal food preferences is attributed to the fact that there is no longer evidence of complaints about the meals featuring in either the complaint system, or in residents' meeting minutes. In addition, data on unplanned weight loss demonstrates that the Elizabeth Knox Home and Hospital ranked second out of 156 for the most recent quarter, and for two years has scored better than the New Zealand and Australasian</p>	<p>Quality improvement processes and proactive responses, including use of a range of feedback and review methods, residents liaising directly and indirectly with the catering staff and dietitian, and health professionals working alongside residents, are progressively enabling residents to have improved dining experiences and meals that more closely meet the residents' individual food preferences as well as their nutritional requirements. This is verified by the current absence of food related complaints and the almost non-existence of unplanned weight loss.</p>

		benchmark.	
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	CI	<p>Benchmarking data of restraint use at Elizabeth Knox Home and Hospital in September 2020 showed that 7.69% of the residents used some form of physical restraint, as opposed to the quality performance system benchmark figure of 5.89%. In October 2020, the restraint coordinator commenced a restraint minimisation project, with an ultimate goal of Elizabeth Knox home and hospital becoming a restraint free environment. Despite physical restraint in an aged care facility being regarded as a high-risk intervention, initial discussions and reasoning with family members, residents and staff on the topic resulted in resistance to the idea. The project leader identified that restraint minimisation would uphold principle seven of the Eden Alternative: Medical treatment should be the servant of genuine human caring, never its master.</p> <p>It was decided that vivid insight and story-telling skills would be used to present ideas with sufficient emotional power for them to be memorable. Specific interventions to support the storytelling approach included capturing prior restraint reduction journeys on a storyboard for later storytelling, identifying residents that required a restraint minimisation review, sharing a story of restraint minimisation with a care team, resident and resident's family (as applicable) and capturing that journey as another story to be told in the next restraint review process. Previous staff training on the art of storytelling had occurred earlier in 2020 and the project built on this foundation.</p> <p>Stories about successful restraint minimisation on storyboards were shared with staff, other multi-disciplinary team members, residents and family members. These have resulted in restraint use being successfully removed from six residents that had previously been hampered by resident, staff and family hesitation towards the removal of restraint. Plans for restraint minimisation for other residents are underway. Staff have reported a greater understanding of restraint minimisation including benefits, challenges and risks. Families have expressed comfort and relief of unspoken anxiety because of stories of prior successful restraint minimisation journeys.</p> <p>There is a suggestion that the success of storytelling in restraint minimisation has the potential to be transposed to support other quality improvement initiatives.</p>	<p>The outcome of a restraint minimisation project that was based on the art of storytelling confirmed that restraint minimisation must not only address the intellectual aspect of rationalising the need for change, but more importantly, evoke emotions in the people involved in the process for them to be at one with the proposed change. Storytelling has been found to be a powerful tool that can be utilised to support restraint minimisation.</p>

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End of the report.