

# Howick Baptist Healthcare Limited

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## 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:

<b>Legal entity:</b>	Howick Baptist Healthcare Limited
<b>Premises audited:</b>	Howick Baptist Home and Hospital
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 14 March 2019 End date: 15 March 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	128

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Howick Baptist Healthcare Limited (HBH) provides rest home and hospital level care to a maximum capacity of 129 residents.

This planned certification audit was conducted against the Health and Disability Services Standards and the provider's contract(s) with Counties Manukau District Health Board (CMDHB). The audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, their family, management, staff, a contracted Eden Alternative consultant and a general practitioner.

The chief executive officer (CEO) is appropriately qualified for the position and is experienced in working in the sector. The senior management team include a range of health professionals.

This audit did not identify any areas requiring improvement and confirmed that corrective actions required by the DHB in 2018 have been implemented.

Seven ratings of continuous improvement were identified. These are in relation to quality monitoring, reducing adverse events, staff education, staff retention, and the provision of services and how these are coordinated and for the onsite activities. Implementation of strategies in these areas has clearly improved services and increased safety and satisfaction for residents and staff.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

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

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. A strategic health plan for Maori and related policies is developed and implemented. There was no evidence of abuse, neglect or discrimination and staff interviewed understood and implemented related policies. Professional boundaries were understood and maintained.

Open disclosure and communication between staff, residents and families is promoted and confirmed to be effective. There is access to formal interpreting services when required.

The service has strong linkages with a range of specialist health care providers which contributes to ensuring services provided to residents are of an appropriate standard.

The organisation has a known and effective complaints management system. All formal complaints are acknowledged in writing, investigated and the results of investigation are reported and shared as appropriate. These are logged on an electronic complaints register held by the chief executive officer (CEO). Each of the complaints on record had been closed off with a comment on the type of resolution reached by the parties concerned. A complaint received by the DHB has been investigated and partially substantiated. The corrective actions required from this have been addressed. There have been no complaint investigations by the Office of the Health and Disability Commissioner.

## 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.

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

The Trust Board provides effective governance. The board meets monthly and are kept informed about all aspects of the organisation.

The CEO and all other members of the senior management team are appropriately qualified for their positions and/or are experienced with working in the aged care sector.

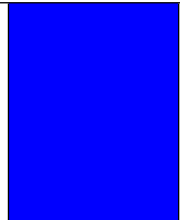
There are well established quality and risk management systems which meet the requirements of these standards. The organisation continues to benchmark its quality data against similar age care services. Risk management systems are fully implemented. All adverse events were being reliably reported and investigated. There have been notifications to CMDHB and the Ministry of Health.

Staff are managed well according to policy and good employer practices. New staff have been recruited in ways that ensure their suitability for the position. Orientation to the service and its policies and procedures, including emergency systems, is provided to all new staff. Ongoing staff education is planned and delivered in ways that ensure that staff receive relevant and timely training on subjects related to their roles and service provision to older people. Staff attendance at mandatory education sessions is monitored. The training is available to all staff through in-service teaching sessions, self-directed learning and presentations by external experts. Aspects of staff training been strengthened. Staff competency assessments and performance appraisals are occurring regularly.

There are enough clinical and auxiliary staff allocated on all shifts, seven days a week, to meet the needs of residents. The allocation of registered nurses (RNs) across the site 24 hours a day seven days a week exceeds contractual requirements. The level of staff retention exceeds other similar organisations.

Residents' information is accurately recorded, securely stored and was not accessible to unauthorised people. Up-to-date, legible and relevant residents' records are maintained in using an integrated hard copy record.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs relevant information is provided to the potential resident/family/whanau to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are supported by care and allied health staff and three designated general practitioners. On call arrangements for support from senior staff are in place. Shift handovers, 'huddles' and communication sheets guide continuity of care and service provision.

Care plans are individualised based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problem that might occur. All residents' records reviewed demonstrate that needs, goals and outcomes are identified and reviewed on a regular basis. The Eden philosophy is embedded through the care planning for each individual resident. Residents and families interviewed reported being well informed and involved in care planning and evaluation

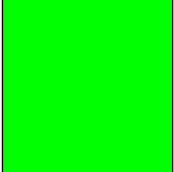
and that the care provided is of a high standard. Residents are referred or transferred to other health and disability services as required with appropriate verbal and written handovers.

The social calendar overseen by the occupational therapist provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and were consistently implemented using an electronic system. Medications are administered by staff who have been assessed as competent to do so.

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

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are safe and effective methods for managing waste and hazardous materials.

The building has a current warrant of fitness. All medical equipment is serviced and calibrated annually. Hot water temperatures are monitored.

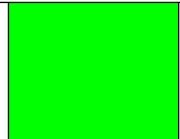
All the bedrooms are for use by a single occupant. The furniture fittings, and building layout are appropriate to the needs of older people. External areas are safe and well maintained. Furniture, fixtures, and all floor and wall surfaces are in good condition including the toilet/shower facilities. All communal areas, such as dining rooms and lounges, are easy for residents to access.

The provision of cleaning and laundry services is hygienic, effective and well managed. These services are monitored regularly to ensure a high standard is maintained.

Fire and emergency systems and the equipment needed for emergencies, including the ability to provide sufficient food and water during a significant disaster/civil defence is routinely checked/tested. There is an approved evacuation scheme and systems for ensuring that all staff can safely manage fire and emergency situations. There is always a staff member with current first aid certificate on site.

Residents' bedrooms and communal areas are heated in ways that provide comfortable and constant internal temperatures.

## Restraint minimisation and safe practice

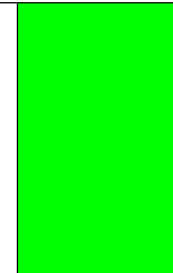
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The restraint policy and procedures comply with this standard and are written in a way that clearly guide staff. On the days of audit there were 17 restraint interventions in place and 10 residents using bedrails as enablers. The need for these had been appropriately assessed and consent obtained. Staff knowledge about the organisation's approach to restraint and their competence in safe application of restraint interventions is tested at least annually.



## Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme is led by the quality and education manager who is a registered nurse. The programme aims to prevent and managed infections. There are terms of reference for the infection control committee which meets six monthly. Specialist infection prevention and control advice can be accessed from the district health board, microbiologist and the contracted general practitioners.

Staff demonstrated good principles and practice around infection control which is guided by relevant policies and supported with regular education.

Aged specific infection surveillance is undertaken, and data analysed, trended and benchmarked. The results are reported through all level 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)
<b>Standards</b>	3	47	0	0	0	0	0
<b>Criteria</b>	7	94	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The organisation has developed policies, procedures and processes to meet its obligations in relation to 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 choices and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training as was verified in the training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Systems are in place to ensure residents and where appropriate their family/whanau are provided with appropriate information to assist them to make informed choices and to give informed consent. The registered nurses and caregivers interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical records reviewed showed that informed consent has been gained appropriately using the organisation's consent forms. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented as relevant in the resident's individual record.</p> <p>Residents interviewed confirmed they have been made aware of and understand the informed consent processes and that appropriate information has been provided. Staff were observed to gain consent for day</p>

		<p>to day care.</p> <p>The GP interviewed understands the obligations and legislative requirements to ensure competency of residents as required for advance directives and reviews undertaken six monthly. Reviews of health status are documented on the appropriate form available and retained in the individual resident's record.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process residents are given a copy of the Code which also includes information on the Nationwide Advocacy Service. Pamphlets and posters related to the advocacy service are displayed and available in the facility. Family members and residents spoken with were aware of the advocacy service and how to access this and their right to have support persons.</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>Residents are assisted to maximise their potential for maintaining independence and links with family and friends in the community by attending a variety of organised activities, visits, shopping trips, entertainment and or activities calendar events. The facility welcomes visitors and encourages visits from residents' family and friends. The Eden Alternative has created an environment that is a home and where residents and family members can have a say and a sense of belonging. Family members interviewed stated they felt welcome when they visited and comfortable in their dealing 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>The complaint management system complies with right 10 of the Code and the requirements of this standard. Review of the electronic complaints register and interview with the CEO confirmed that all complaints received since the surveillance audit in 2017 have been addressed and resolved. One complaint from a family to the Office of the Health and Disability Commissioner in 2017 was not investigated or progressed by them. A complaint to the DHB in early 2018 has been thoroughly investigated by them. The investigation substantiated some aspects of the complaint. The corrective actions still outstanding included providing staff with education on the receiving and management of complaints. Education has been provided and changes implemented to prevent recurrence. There has been significant improvements in activities (refer standard 1.3.7) and responses to challenging behaviours (refer standard 1.2.4). These were confirmed by observations, documents reviewed and staff, residents and relatives interviewed.</p> <p>The records showed that each complaint has been resolved to the satisfaction of the complainant.</p> <p>All concerns, complaints or compliments are entered into the software system as soon as they are received. Details about the matter and its progress is then accessible to the CEO and authorised senior staff.</p>

		Significant matters are discussed at monthly senior management meetings and reported to the board. Staff, residents and their family members interviewed demonstrated knowledge and understanding of the complaint process. Families described staff as being open, responsive and keen to address any matters they raised with them.
Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights.	FA	Residents interviewed reported being made aware of the Code and Nationwide Health and Disability Advocacy service (Advocacy Service) through the social worker and registered nurses as part of the admission information provided and the discussion with staff. The Code is displayed in all service areas together with information on advocacy services, how to make a complaint and feedback forms.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>The independence, dignity and respect policy reviewed includes the philosophy of maintaining the residents' independence and encouraging individuality. The sexuality and intimacy policy provides guidance for staff on residents' rights as well as staff responsibility for the safety of residents. Guidance on managing inappropriate behaviour is included. The process for accessing personal information is detailed.</p> <p>The family/whanau members and residents interviewed reported that they are treated in a manner that shows regard for their dignity, privacy and independence. All residents have a single room and interviews with residents/family are held in private. There is also a lounge with a telephone for residents' use or meetings. A church service is held weekly and residents, if able, can attend church in the community. The service has their own chaplain on site at the facility.</p> <p>The residents' records reviewed indicated that residents receive services that are responsive to their needs, values and beliefs of culture, religion and their ethnicity. Residents and family members reported a high level of satisfaction with all levels of care they receive.</p> <p>As observed on the day of the audit and confirmed with review of the individual resident's records randomly selected, residents receive services appropriately to meet their needs. No concerns in relation to abuse and neglect were reported from residents, the GP, family and/or staff interviewed. Comments made reflected a positive atmosphere from family.</p>
Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a	FA	A strategic health plan for Maori is available for the identification and planning of care needs for Maori residents. This includes a range of cultural issues/considerations for staff to be aware of to ensure the provision of culturally appropriate care to Maori residents. Family/whanau input and involvement in service delivery is sought if applicable. When required, other supports are accessed. Best practice principles are identified. A commitment to the Treaty of Waitangi is included. Staff are provided with training on the

<p>manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>provision of culturally appropriate care.</p> <p>There is one resident who identified as Maori and respect for the individual cultural needs were maintained and tikanga practices adhered to. Caregivers and care partners (activities assistants) interviewed were aware of meeting the cultural needs of each resident. Extended whanau/friends are welcome anytime and to join in the Eden Alternative activities programme. The service promotes equal access to services for Maori residents. Identifying and eliminating barriers for Maori residents/kiritaki that are within the control of the organisation is encouraged. There are four staff members who identify as Maori.</p> <p>Staff understood the service's policy on abuse and neglect including what to do should there be any signs. Education on abuse and neglect was confirmed during orientation and annually.</p> <p>There is a Maori advisor available to the service if and when required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>All residents at this facility have equal access to services and are not discriminated against or prejudiced because of race, sex, creed, gender and/or religious beliefs.</p> <p>The social worker who manages the initial contacts with the service and registered nurses ensure that any cultural needs are identified on admission and are communicated to the caregivers who provide the majority of personal care to residents. Staff reported they received training in cultural awareness. Cultural needs are documented on the resident's interRAI information records and the momentum care plans reviewed, inclusive of which iwi the resident belongs to.</p> <p>The residents' records reviewed demonstrated consultation with both family/whanau on individual values and beliefs. The family/whanau and residents interviewed reported they are consulted with the assessment and care planning development.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p>	<p>FA</p>	<p>The organisation's philosophy is adhered to and the service encourages and promotes good practice through providing a caring environment. The Eden Alternative is a philosophy of care that has been adopted</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>by the organisation for four years which has transformed residential care at the facility by addressing the 'three plagues' of older people; loneliness, helplessness and boredom. An 'Eden coach' has been employed by Howick Baptist Home over the last year to assist with additional mentoring and growth of the 'Activities Team' and to add depth to the programme by increasing resident participation towards the 'Edenising' process. This has been fully embraced by residents, family and staff. This philosophy is well embedded across the organisation and was clearly demonstrated during this onsite audit.</p> <p>The clinical quality manager, registered nurses and team leaders promote and encourage best practice with staff. Evidence of this was demonstrated in interviews with the registered nurses, team leaders and caregivers. Additional professional support is sought as required from nurse specialists, wound care specialists, a psycho-geriatrician and the hospice palliative care team.</p> <p>A planned education programme organisation wide for both registered nurses and caregivers is held annually to cover all mandatory training. Staff reported they receive management support for external education and access to their professional networks to support contemporary good practice. A large education room is available onsite. Journals and textbooks are available. Management support is available to promote and provide best practice. Nursing and occupational therapist students are on placement at the facility and were seen to be well supported by staff.</p> <p>The general practitioner interviewed confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</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 residents' records reviewed. Staff interviewed understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff understood how to access interpreter services when required through the DHB.</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>Howick Baptist Healthcare have agreements with CMDHB to provide age residential care for hospital geriatric and rest home services, respite/short term care, services to people with long term chronic health conditions and a day activities programme. There are also contracts with the MoH and the local Needs Assessment and Service Coordination (NASC) agency for as needed services such as Primary Options for Acute Care, and young people with disabilities. On the days of audit there were 128 residents on site. Thirty-two of these were assessed as requiring rest home level care and 96 as requiring hospital care. There was no one there on respite and one resident was under the age of 65 years.</p>

		<p>The CEO advised there have been no changes in the service scope or configuration since the surveillance audit in 2017.</p> <p>The organisation's vision, mission, values and annual goals are in the 2019 Quality Risk Management and Strategic Plan. This is reviewed regularly with the board who meet monthly with the CEO to consider all operational and financial business. Review of the reports to the board showed they are provided up to date information on occupancy rates, health and safety matters, audit outcomes, staffing information, financial reports, information about complaints and compliments received, resident care, quality and other service delivery matters. Changes within the board membership were occurring at the time of the audit but were still to be ratified. (Refer standard 1.2.4)</p> <p>The CEO who has been in the role for 15 years, has extensive experience as a manager in the health sector and is qualified in business management and leadership. The Director of Nursing who has been employed by the organisation for 38 years, is a registered nurse with extensive clinical and managerial experience in aged care. The Property Services Manager who is the appointed Health and Safety Officer, has long term experience with building and project management. A new Quality and Education Manager took up the role in late 2017. Review of personnel files and interviews confirmed that all senior management staff are qualified for their roles and maintain their skills and knowledge by attending regular professional development and industry conferences.</p>
<p><b>Standard 1.2.2: Service Management</b></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>	FA	<p>Temporary cover during the CEO's planned absences is shared amongst the senior management team, usually by the clinical and property managers. Interviews with all levels of staff confirmed this arrangement is proven to be effective and ensures continuity for staff, residents and their families.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system</p>	FA	<p>The quality and risk management system is well established and integrated across all areas of service delivery. A new policy and procedure set is being introduced. Staff interviewed confirmed the transfer to a new set of forms and policies is being managed well. The policy set in use is industry standardized by an external consultant and all are controlled and reviewed at least two yearly or when changes are indicated. Changes require authorisation at senior management level. A pre audit documentation review revealed that policies were current.</p>



<p>that reflects continuous quality improvement principles.</p>	<p>Quality monitoring includes regular checks and audits of service delivery and the collection, reporting and benchmarking of quality data. The quality and education manager prepares and collates quality data for external benchmarking and internal reporting and trend analysis. This information is presented and discussed at board level, management meetings, and at the Continuous Quality Information Committee (CQI) meetings. The CQI committee, who comprise the quality and education manger, the CEO and all senior managers, meet monthly to report across their service areas and share quality data. More distillation of quality and risk matters are reported and discussed at a range of staff meetings (for example, RN meetings, Health and Safety meetings, and regular meetings of caregivers across shifts in each community). The sample of meeting minutes reviewed showed that resident care, including their adverse events, health status, infections and behavioural concerns, are discussed at RN meetings, and at hospital and rest home staff meetings. Senior managers review incidents/accidents, complaints, staffing, financial and project matters at their meetings and the health and safety committee consider staff injuries and the impact of environmental issues on services.</p> <p>A range of staff are involved in quality and service monitoring (for example, internal audits, quality improvement projects, and other initiatives or methods to improve services). The organisation demonstrated a strong commitment to 'getting things right' and to continuous quality improvement. This was demonstrated by the extent of quality projects presented at audit (nine) and the planned and reviewed approach over three years for implementation of the Eden Alternative.</p> <p>Where audits, incidents, complaints or feedback identify deficits, these are reported verbally and in writing. A range of corrective actions are discussed with relevant people and the most suitable actions are implemented.</p> <p>A continuous improvement rating is awarded in criterion 1.2.3.6 for successes achieved as a result of implementing a new approach to internal benchmarking. The organisation continues to participate in the 'QPS' benchmarking programme which compares indicators with similar aged care facilities across Australia and New Zealand. This information is analysed by the senior management team to identify trends and is reported quarterly to the trust board.</p> <p>Risk management processes are integrated with the quality monitoring system. The current risk management plan includes service provision, human resources, natural disaster planning, health and safety, contractual compliance and financial risks. The health and safety committee report all matters that require communication and discussion at staff and management meetings. Environmental checks to assess for health and safety are conducted regularly and reactive facility maintenance occurs. Chemical safety data sheets which provide information about hazardous chemicals are displayed in various locations on site.</p> <p>Health and safety and essential emergency processes are mandatory topics during orientation and as part of the annual staff education plan. The interRAI assessment process identifies each resident's clinical risks and service delivery plans described how these will be mitigated.</p>
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<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>There are well established and managed processes for the reporting, recording, investigation and review of all incidents and accidents. This was confirmed by a sample of accident/incident forms reviewed on the days of audit, other documents related to the collation and analysis of incidents, meeting minutes, board reports and section 31 notifications. Interviews with the quality and education manager, other senior managers, the CEO, RNs, care staff and allied staff, revealed that the adverse event reporting system is well known and understood. Incidents are discussed at shift handover, and trending data is displayed in the staff rooms. Each resident's care record contained a summary of incidents which facilitates a ready review of risks. The event reports showed that people impacted by the adverse event are notified.</p> <p>The event records showed that reporting occurs immediately to the team leader and to the director of nursing, who investigates to determine cause and prevent or minimise recurrence. All the event data is then collated monthly. (Also refer to criterion 1.2.3.6 for timeframes and process) by the quality and education manager. This data is discussed monthly by the CQI committee, reported monthly to the board and further evaluated by the CEO and other senior managers each quarter. Howick Baptist Healthcare continues to receive three monthly benchmarked comparisons of events against similar size and same scope age care facilities in Australia and New Zealand.</p> <p>Interview discussions and the content of meeting minutes verified the ways in which the system is designed to predict, avoid and/or mitigate adverse events and to ultimately prevent recurrence.</p> <p>A continuous improvement rating was awarded in 1.2.4.3 in recognition of the speedy response to a spike in challenging behaviour.</p> <p>All senior managers are conversant with and understand their statutory and regulatory obligations in regard to essential notifications and reporting. There have been no deaths referred to the coroner, nor any police investigations in this certification period. The organisation has notified a staff injury to WorkSafe, and three reports of pressure injuries and three notifications for outbreaks have been made to the MoH and CMDHB in 2018. The appointment of two new board members and a new chairperson was in process during this audit and will be notified once appointments have been ratified and completed.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	<p>FA</p>	<p>Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. The sample of staff records reviewed confirmed the organisation's policies for recruitment and performance management are being consistently implemented. Recruitment, appointment and ongoing employment records are being maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. The orientation programme</p>

<p>practice and meet the requirements of legislation.</p>		<p>continues to be reviewed and updated. All new staff now have one to one training on manual handling and other subjects related to occupational health and safety before starting work. New staff reported that the orientation process prepared them well for their role. The staff records reviewed contained proof of completed orientation followed by an initial performance review after 90 days.</p> <p>Staff education specific to age care is planned over a two year period and covers a range of topics. Some educational topics are mandatory for staff to attend annually, such as emergency management, infection control, and medicines management (if administering medicines). The RNs and specialist staff are provided with additional training pertinent to their roles or as necessary for them to maintain annual membership with their professional bodies (eg, physiotherapists, social worker, occupational therapists, and maintenance, domestic and kitchen staff.)</p> <p>The organisation is very focused and invested in ensuring that every staff member fully understands, and practices in ways that enact each of the 10 principles of the Eden Alternative. Howick Baptist are now in their fifth year of implementation, having gained eight principles (2, 3, 4, 5, 6, 7, 8 &amp; 10) they are waiting to be audited against the remaining two principles to achieve full registration. Senior management have created and adopted new approaches to educating staff. The Eden Educational guide developed in house, has proven to be successful and is receiving international recognition. A continuous improvement rating is awarded in criterion 1.2.7.5 for the measure of success achieved.</p> <p>All care staff are expected to commence age care sector training (as outlined in their pay equity settlement) three months after commencing employment, if they do not already have qualifications. At the time of this certification audit a large percentage of care staff have achieved qualifications in age care, as follows:</p> <p>ACE Programme (3), ACE Advanced (4), NZC HW Health Assistance Level 3 (15+7 in progress), NZC in HW Advanced Support-Level 4 (23+2 in progress),</p> <p>ACE Dementia (4), ACE LCP Res (12), LCP V3 (3+1 in progress) This is a total of 74 caregivers (from approximately 100 caregivers) who are employed on varying hours.</p> <p>A goal to increase the level of educational achievement in caregivers is in progress. RNs and ENs are maintaining the competencies required to retain their Annual Practising Certificates (APCs). Six RNs are maintaining annual competency requirements to undertake interRAI assessments and others are in the process of interRAI training.</p> <p>Each of the staff files and other staffing records audited contained evidence of ongoing education and that annual performance appraisals were occurring.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>CI</p>	<p>Observations and review of the rosters and interviews with all levels of staff confirmed there are appropriate numbers of staff on site 24 hours a day, seven day as week (24/7) for the number of residents and services</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>required. The number of RNs, ENs and caregivers allocated on each shift in the rest home and hospital communities meet the ARCC requirements for the number of residents in care (maximum 129). The organisation employees approximately 200 staff which equates to 90 full time employed (FTE) staff. A full time director of nursing oversees the care being delivered to all residents Monday to Friday. Each community has allocated RNs and team leaders.</p> <p>The rest home roster (for 32 residents) has three caregivers, a team leader and an EN for the morning shift, a team leader and two carers for the afternoon shift and two caregivers at night. Each of the four hospital communities (24 beds each on average) have six caregivers and two RNs rostered on for morning shifts, three caregivers and one RN in the afternoon and three caregivers at night with two RNs overseeing two hospital communities. These rosters are the same seven days a week and the allocator ensures there is at least two staff members with a current first aid certificate on duty at all times (all RNs and ENs are maintaining comprehensive first aid certificates).</p> <p>The staff interviewed said there were sufficient numbers of staff, for the needs of the residents, allocated across all shifts. Additional staff are rostered on when workloads increase for any reason. There has been minimal to no usage of agency staff as the organisation maintains a reliable pool of casual staff.</p> <p>An appropriate number of additional auxiliary staff are on site at various times and days (for example, activities staff (also called care partners) and occupational therapists, physiotherapist/rehabilitation assistants, kitchen staff and cooks (outsourced), cleaners and laundry staff, management, social worker, administration and maintenance staff) for the size and scope of the services.</p> <p>Residents and family members interviewed expressed satisfaction with the availability of staff and the services provided.</p> <p>HBH has very little turnover of staff. Its staff retention rates are much higher than the industry average. A rating of continuous improvement is awarded for successes achieved in retaining staff.</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>Personal information was entered in all residents' records sighted. Records are maintained in an integrated folder with divisions for each section. There is a contents list at the front of each individual resident's record.</p> <p>All entries were documented clearly and were legible with appropriate signatures and designations as required.</p> <p>The resident register is maintained electronically.</p> <p>Residents' records are stored appropriately and securely. Archived records are stored in a manner that they can be retrieved if required. Records are not accessible to the public or unauthorised persons. Consent is obtained on admission to this home for residents' names to be placed on the doorways of their rooms.</p>

<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>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or families are encouraged to visit the facility prior to admission and meet with the social worker designated to manage all enquiries and/or the facility administrator. They are provided with written information about the service and the admission process. The organisation seeks updates information from NASC or the general practitioner 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. Records reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. All residents at the facility have been pre-assessed prior to admission as required, whether for rest home or hospital level care. The social worker has recently implemented and six week post admission audit as a new initiative to assess whether the pre-admission and admission procedures require any quality improvements.</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>	<p>FA</p>	<p>The quality manager interviewed stated risks are identified prior to any planned discharges. Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHBs `yellow envelope` system to facilitate transfer of residents to and from acute services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including the medication records is provided for the ongoing management of the resident. All referrals are documented in the progress records. Family reported being kept well informed during the transfer of their relative to the DHB.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management. A safe system for medicine management was observed on the days of the audit. The staff observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription and entered into the electronic system. All medication sighted were within current use by dates. Clinical pharmacist input is provided on admission for each resident, reconciliation of all medication occurs, and six-monthly audits are completed. The medicine records are reviewed electronically by the GP every three months or as required. All medication records have a photograph of the resident to assist with the identification of the resident.</p>

		<p>Photographs used for resident identification are dated. Additional hard copy medication records for use of topical ointments or other non-regular medication is reviewed three monthly by the GP.</p> <p>The records of temperatures for the medication fridge are within the recommended range. The requirements for pro re nata (PRN) medicines is met. Allergies and sensitivities are recorded on the medication records and on the residents' individual records.</p> <p>There were two residents self-administering medications at the time of the audit. Appropriate processes were in place to ensure this is managed safely.</p> <p>Any medication errors are reported to the team leader and/or the registered nurse and recorded on an incident form. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used. The three medication trollies are stored in the locked medication rooms when not in use in each area of service delivery.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></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>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration - expiry is 07 April 2019. Food temperatures, including high risk items, are monitored appropriately and recorded as part of the plan. The qualified chef interviewed who is employed by a contracted service provider has undertaken a safe food handling qualification with kitchen assistants at the main kitchen also completing relevant food handling training. The chef attended a chef training workshop 1 February 2019. The two main meals, lunch and dinner, are served in the dining rooms in each area of service. Residents have a choice of having breakfast in the dining room or in their own room. Staff assist with placing meals on the tables from the servery provided. Care staff are responsible for assisting residents with their meals and the kitchen hands clear the tables and wash the dishes after the two main meals.</p> <p>The menu used is a four week rotating menu that follows summer and winter patterns and has been reviewed by the contracted organisation's dietitian within the last two years (18 October 2018). The summer to winter menu changes on the 1 June 2019. The menu is displayed daily in all service areas of the facility.</p> <p>A dietary/nutritional assessment is undertaken for each resident on admission by the registered nurse and a dietary profile developed. The chef stated that he visits all residents. The personal food preferences, any special diets and modified texture requirements are made known to the chef. Kitchen hands are guided by the information displaying the dietary needs of residents on a whiteboard in the kitchen to ensure the special needs of the residents are met. Additional food and nutritional snacks are available 24 hours a day. The families and residents interviewed reported they were satisfied with the food and fluid service.</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>	FA	<p>If a referral is received but the prospective resident 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. If the needs of a resident change and they are no longer suitable for the service offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and family/whānau. There is a clause in the access agreement related to when a resident's placement can be terminated. An electronic system is used as a data base used for all resident information and this is well maintained by the social worker and administration staff.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All new residents admitted to this service have an interRAI assessment completed after three weeks of admission by their primary nurse. The assessments include the review of any previous interRAI assessments, such as homecare, and/or needs assessment service coordinators comments. Additional information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, pressure injury, nutritional/dietary screening and depression scale if required, as a means to identify any deficits and to inform care planning. The sample of resident centred care plans reviewed had an integrated range of resident related information. All residents have current interRAI assessments completed by one of the six trained interRAI assessors on site.</p> <p>Residents, staff and families interviewed reported appropriate care is provided that meets identified needs.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Resident centred care plans evidence service integration with progress records, activities records, medical and allied health professional's notations clearly written, informative and relevant. Any change of care required is documented and verbally passed on to relevant staff.</p> <p>The Director of Nursing and registered nurses interviewed demonstrated understanding of the interRAI process.</p> <p>The resident-centred care plans and activities plans identified resident's individual activities, motivational and recreational requirements with documented evidence of how these are managed effectively for the individual resident. Appropriate interventions in line with the Eden Alternative philosophy were documented on each care plan sighted.</p> <p>Residents and families reported participation in the development and ongoing evaluation of care plans.</p>

		The registered nurses team leaders, general practitioner and caregivers reported they receive adequate information to assist with the continuity of care for each individual resident.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. Care staff interviewed confirmed that care was provided as outlined in documentation. The service has a range of equipment and resources, such as wound dressings and continence products, readily available suited to the levels of care provided and in accordance with the individual resident's needs.
<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>	CI	<p>The monthly social calendar events (sighted) was developed based on the resident's needs, interests, skill and strengths. A weekly plan is displayed in all service areas/communities and in the individual resident's room. The community living team is made up of four experienced living care partners. The occupational therapist oversees the programme. The community living care partner coordinator works Monday to Friday. There is coverage for morning and afternoons in each community. In the weekends a trolley is set up with resources being available for staff to provide additional social activities. The coordinator covers all communities and evaluates and reviews the individual resident's participation in activities with the assistance of the care partners. The goal is to 'Edenise' the total facility. Education is provided for all staff. 'Spark of Life' training is also provided by the occupational therapist who is fully trained to implement the club level training for a research project underway.</p> <p>The sighted social calendar covers cognitive, physical and social needs. A different theme is provided monthly in each community. The activities are modified to suit the individual needs and capabilities of each resident. There are group and individual activities provided. The aim is to engage residents' interests and long-term memories. The community living team coordinator interviewed reported that the Eden Alternative philosophy has contributed to a new dimension enabling residents to do as much as they can themselves, as they would at home. This gives the residents a sense of purpose and belonging and meaningful activities reflected normal life interests. The community living team coordinator also reported that there is an element of flexibility to change activities based on the resident's response. Photos of events are placed on the display notice boards in each community on a regular basis. Eden growth goals are displayed along with a 'kete' for (Principle 6 – cultural appropriateness) in each resident's room for the care partners and whanau/family.</p> <p>The service provides easy access by using the total mobility van for outings into the community.</p> <p>The HBH Beacon is a monthly newsletter which is distributed to all residents, family/whanau and staff.</p>



		<p>Families are encouraged to join in the daily activities programme and special events are planned and family are invited. A church service is held monthly. The service has their own Chaplain who has an office central to all residents. Communion is available and Christian groups are welcome to visit the facility. Volunteers are trained to aid residents and to assist with the activities provided.</p> <p>Family/whanau and residents report that they enjoy a range and variety of planned activities. Residents are encouraged to maintain links with family/whanau and the community. Special events are celebrated for example birthdays, anniversaries, cultural days and other special events.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress records. If any change is noted, it is reported to the registered nurses.</p> <p>Formal resident centred care plan evaluations, occur every six months in conjunction with the six monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for behaviour management, following falls, skin tears, pressure injuries, and progress was evaluated as clinically indicated and according to the degree of risk noted during the assessment process. The caregivers interviewed demonstrated a good knowledge of short term care plans and reported that these are identified, and information is shared at handover between shifts.</p> <p>Other plans, such as wound management, were evaluated each time the dressing was changed. Residents and families/representatives interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> <p>There was evidence of multidisciplinary reviews being undertaken in the records reviewed.</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 or seek referral to other health and/or disability service providers. Options are provided when required. Although the service has three contracted general practitioners, residents may choose to use another medical practitioner. The GP interviewed visits residents after hours. The GP commented that services responded promptly to referrals sent.</p> <p>If the need for other non-urgent services is indicated or requested, the GP sends a referral to seek specialist input. Copies of referrals sighted in residents' records, included orthopaedic, eye clinic, mental health services for older persons, dietitian and other specialists. Referrals are followed up on a regular basis by the general practitioner. The resident and the family/representative are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to the DHB if the circumstances dictate.</p>

choice/needs.		
<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>	FA	<p>All staff who handle chemicals (for example, laundry, cleaners, and maintenance staff) have completed safe chemical handling training. An external company is contracted to supply and manage chemicals and cleaning products and provide staff with product information. No adverse events related to chemicals have occurred since the previous audit. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. Appropriate signage is displayed where necessary.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness expiring on 04 March 2020 was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained as confirmed in documentation reviewed, interviews with management and maintenance personnel and environmental inspection. Testing and calibration of hoists, electric beds and bio medical equipment occurs annually or more frequently when required. The facility is fitted with a Residual Current Device (RCD) which constantly monitors electric current and provides protection against fatal electric shock. Regular testing and tagging of electrical equipment is therefore not required.</p> <p>Maintenance staff conduct regular checks of equipment (walkers and wheelchairs) and carry out minor repair work. There is a preventative maintenance schedule which is adhered to. Staff confirmed they know the processes they should follow if any repairs or maintenance is required, and said requests are actioned in a timely manner.</p> <p>The internal environment is hazard free, residents are safe and independence is promoted. External areas are well maintained, safe and fit for use by residents.</p> <p>The three vehicles used for resident transportation have a current warrant of fitness and registration.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	FA	<p>Each of the resident's bedrooms has a toilet, and all but 10 bedrooms have attached shower/bathrooms. Shared bathing/shower facilities are used by residents who require full staff support to shower or bathe. There have been no issues with maintaining consumer privacy when attending to personal hygiene needs. Hot water monitoring is occurring monthly and temperatures are well within safe limits of below 45 degrees. Residents and families interviewed were very happy with the facilities.</p>

facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All bedrooms have a single occupant. The rooms are spacious and contain a generous king size single bed, at least one easy chair, wardrobe and clothes storage units and bedside tables. There is enough room for the resident to move around safely with or without a mobility aid. Residents and families interviewed were very happy with the facilities.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Each 'community' has its own and unique communal areas for residents to engage in recreation, visiting or dining. These areas reflect the needs and personalities of the individuals who reside there. For example, one community has created an additional sitting area for 'at risk' residents which is located in a high traffic area outside the lifts and close to staff. This has increased the resident's interaction with each other and visitors and significantly reduced falls and wandering. In total, there are nine lounges and five dining rooms. A thriving 'community space/centre' and separate physiotherapy gym are located centrally and are easily accessible for all residents. A quiet room is available for family who are supporting unwell residents.  Furniture is in good condition and appropriate for the people who live there.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Designated cleaning and laundry staff are on site seven days a week. These staff have achieved qualifications in safe handling of chemicals and are provided with ongoing health and safety education from the health and safety officer. This was confirmed in interview with staff and review of their personnel records.  Staff follow established routines for cleaning and all areas are maintained as hygienic. Site inspection revealed no concerns with cleaning. Chemicals are stored securely and are decanted into clearly labelled containers.  All the laundry is being managed on site according to known protocols for dirty/clean flow and the handling of soiled linen. Improvements have been made to soak basins, storage bins and by moving an extra washing machine into the laundry There have been no concerns expressed from staff, resident or relatives about cleaning or laundry services since the previous surveillance audit in 2017. Household staff effectively

		<p>managed the increased demand on their services during three norovirus outbreaks in 2018.</p> <p>Cleaning and laundry processes are routinely being monitored for effectiveness via the internal audit programme, from the external cleaning product supplier and through resident/family surveys and feedback.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan has been approved by the New Zealand Fire Service. Trial evacuation drills are occurring every six months and all staff are attended fire and emergency updates annually. The orientation programme includes fire and security training.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the maximum number of residents (129). Potable water is stored in the building, plus 2,500 litre capacity water tanks are on site. Apart from a backup battery for lighting (which is regularly tested) there are no generators on site for power outages. The protocol is to hire one.</p> <p>Call bells alert staff to residents requiring assistance. Staff were observed to respond within reasonable timeframes to these.</p> <p>Appropriate security arrangements are in place. Security patrols visit each evening. Doors and windows are locked at a predetermined times from 8pm and after the evening shift.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All rooms have natural light and opening external windows. Heating is provided via underfloor water radiators and electric panel heater with individual controls in residents' rooms and in the communal areas. Residents and families interviewed said the facilities are maintained at a comfortable temperature during all seasons.</p>
<p>Standard 3.1: Infection control management</p>	FA	<p>The infection control programme and manual are reviewed annually. The service provides a managed environment that minimises the risk of infections to residents, staff and visitors through the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by</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>a comprehensive and current infection control manual, developed at organisational level, with input from quality and education manager who is also the infection control coordinator.</p> <p>The infection control coordinator (ICC) is an experienced registered nurse/quality and education manager whose role and responsibilities are defined in a position description. The infection control coordinator has been in this role for four months. Infection control matters, including surveillance results, are reported monthly to the director of nursing, and tabled at the quality/staff meetings. The infection control committee includes representatives from all areas of service delivery including an enrolled nurse, the quality and education manager/ICC, director of nursing, a kitchen representative, a health care assistant and any staff with an interest in infection prevention and control. The committee meets six monthly.</p> <p>Signage at the reception to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICC is supported by the director of nursing. Well established local networks with the infection control team at the DHB are available and expert advice from the community laboratory is available if additional support/information is required. The ICC has access to the residents' records and to diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. There have been three infection outbreaks at this facility since the previous audit. Five communities were affected and also staff. A full report of the outbreak management was reviewed.</p> <p>An outbreak management plan is developed and available for any event and 'lockdown' of the facility would be instigated and communities (wings) can be closed off respectively.</p> <p>The ICC, registered nurses, kitchen representatives and caregivers interviewed demonstrated good infection prevention and control techniques and awareness of standard precautions such as hand washing and the use of personal protective equipment.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current</p>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard. Policies were last reviewed April 2018 and included appropriate referencing. There are clear definitions of infections and an identification of infections form available. There is a notifiable diseases list in the manual sighted. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitises, good hand washing technique and use of personal protective equipment, such as hats, disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed</p>

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.		demonstrated safe and appropriate infection prevention and control practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the infection control coordinator. Content of training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.</p> <p>Education for residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their own room if they are unwell. Increasing fluids for residents is promoted by care staff.</p>
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented on the infection clinical record. The infection prevention and control coordinator reviews all reported infections by community and maintains a log for each type of infection. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and any required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers observed. Graphs are produced for each of the five communities that identify trends for the current year, and comparisons against previous years and this is reported to the director of nursing. Data is benchmarked with the five communities. Infection rates in the facility are below average for the sector.</p>
Standard 2.1.1: Restraint	FA	The service policies meet the requirements of these standards and provide guidance on the safe use of both

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>restraints and enablers.</p> <p>On the days of audit, 27 residents were using bed rails and/or lap belts as restraint interventions or enablers. Ten of these interventions had been initiated and requested by the resident's enduring power of attorney (EPOA). The restraint register listed 17 residents using bed rails and/or lap belts as restraints and ten residents who had requested either a bed rail, lever or lap belt when sitting to enable and increase their safety or mobilisation. The same assessment and consent process is followed for the use of enablers as is used for restraints.</p> <p>A sample of six residents' records reviewed, contained evidence that a comprehensive assessment of the resident's status and risks had been conducted prior to implementing a restraint intervention and that alternatives had been tried. Approval to use restraints are granted by the restraint committee and valid consent is obtained by either the resident or their authorised NoK or welfare guardian. There was evidence of ongoing monitoring and review of each restraint intervention.</p> <p>Training records and interviews showed that all staff attend at least one education session on restraint and management of challenging behaviour and use of de-escalation each year. All new staff are provided with information about the restraint policy, philosophy and approach during their orientation.</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>A long time employed senior RN with extensive experience in aged care is the designated restraint coordinator. The role and responsibilities are contained in a position description which describes oversight of all restraint in use with support from the restraint committee. This person provides support and oversight for enabler and restraint management throughout the facility and demonstrated a sound understanding of the organisation's policies and procedures and the practices required from this standard.</p> <p>The restraint approval committee is comprised of all team leaders, the director of nursing, and the quality and education manager. The committee convenes every three months or as needed to review and consider restraint assessments and make approval. There was clear approval for use of restraint on the records reviewed and interview with the coordinator confirmed clear lines of accountability. Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of 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</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The restraint coordinator described the documented process which involves them undertaking the initial assessment with input from the other RNs and the resident's family/whānau/EPOA. Families confirmed their involvement. The general practitioner signs off as part of the decision to use a restraint intervention. The assessment process identified the underlying cause, history of restraint use, cultural considerations,</p>

use of restraint.		alternatives and associated risks. The desired outcome was to ensure the resident's safety, security and promote mobilisation. Fully completed assessments were sighted in the records of residents who were using a restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>The use of restraint is actively minimised through the use of low beds, alarm mats and 'noodles' to prevent any rolling out of bed.</p> <p>The alternatives considered and trialled were documented in the restraint forms and in the care plan. Caregivers and staff are aware of alternatives and seek new ideas.</p> <p>The restraint register records the type of restraint in use, the frequency of monitoring and review and the date it was initiated. An electronic restraint register is maintained, reviewed and updated by the restraint coordinator whenever a change is made. The register sighted contained all residents currently using a restraint and sufficient information to provide an auditable record.</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 provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>Staff meeting minutes showed that use of restraint, policy and procedures and related topics are discussed frequently. Staff attend mandatory education and must pass an annual restraint competency test. The staff interviewed understood that the use of restraint is intended to be minimised and how to maintain safety when a restraint is in use.</p>
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 by the restraint coordinator every three months and evaluated during care plan and interRAI reviews. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of this Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review	FA	<p>Interview and the documentation sighted (for example, a sample of eight restraint committee meeting minutes, the documented 2018 quality review, RN and staff meeting minutes) confirmed that a comprehensive review of restraint use/trends has occurred since the previous audit. The restraint coordinator consults with the quality and education manager about the frequency and efficacy of staff education on restraint and whether changes are required.</p>



of their use of restraint.		
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## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The collection, collation, analysis and feedback of quality improvement data has been established for many years as an effective method for monitoring service delivery. But it was taking the new quality manager a lot of time to ‘drill down’ into the quality data collected (staff incidents, medicine errors, infections, challenging behaviour, pressure injuries, falls, skin tears/bruises) because the system was designed to compare differences in the statistics between the rest home and the hospital, and the external benchmarking results were at too higher level. A new approach to internal benchmarking was initiated in January 2018. The statistics started being compared across each of the four hospital communities on site. Each community has on average 24 hospital beds. This immediately revealed where the trends were occurring and allowed the source of problems to be quickly identified. The staff became more engaged in the quality data being presented to them. For example, staff began	The new approach to internal benchmarking has resulted in identifying sources of problems quicker, allowing immediate solutions to be implemented, and has increased staff understanding and engagement. It has become a reflective learning experience. Evidence of this is shown in criterion 1.2.4.3 regarding a spike in challenging behaviours in one community which was contained to bring the number of events back under the benchmark within a month. Staff interviewed demonstrated how much more engaged and curious they were with the quality data.

		questioning why medicine errors were higher or non-existent in different communities, and discussing other differences, seeking to understand why.	
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	CI	<p>A spike in challenging behaviour events in April 2018 (for example, 14 events which exceeded the organisation's benchmark of one event per month) triggered an immediate investigation, review of antecedents and the overall staff management of residents exhibiting challenging behaviour. These events spiked in two separate communities and were not necessarily related to single residents. All event records and behaviour monitoring forms were reviewed to consider how well triggers had been identified and communicated, and the effectiveness of the de-escalation methods used in each case. A range of interventions were tried for specific residents (for example, changes in lighting in one community). The event form (accident and incident form) was amended to include a link if the event is behavioural (wandering, aggression) and a behaviour monitoring form was created, which provides opportunity to track a resident's behaviour over 24 hours and/or periods of days. Staff received training on using the new forms and a specific education session on de-escalation techniques was provided. Advice was sought from the local Mental Health of Older Persons service and the regular mental health nurse and an agreement that the pharmacist be involved with all reviews of challenging behaviour. All of these interventions reduced reported challenging events back to the benchmark or below the following month (May 2018) and for the remainder of 2018</p>	<p>New protocols and systems for the effective and timely management of challenging behaviour events have been implemented with good effect. All communities are now tracking on or below the organisation's benchmark of one event per month.</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan,</p>	CI	<p>HBH have contracted a part time Eden consultant who is onsite two to three days a week to fully imbed practices by coaching, mentoring and overseeing developments.</p>	<p>The Eden Educational guide developed by HBH has been recognised by the Board of Eden in OZ &amp; NZ (EIONZ) and will be presented at conference in 2019.</p>

<p>facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>		<p>Senior staff have developed their own Eden Education Guide which has been selected for presentation at an international Eden conference in 2019. This guide has been designed as a self-directed learning tool, replacing the usual 'didactic' teaching methods with a more experiential and self-initiating approach. This tool has been trialled since 2018.</p> <p>Uptake of the Eden philosophy is measured by various means including conducting an extensive cultural assessment, which gathers information from residents, relatives and staff. The most recent organisation wide cultural assessment revealed considerable advancement from an average score of 221 in April 2018 to an average score of 268 in March 2019.</p>	<p>The effectiveness of the educational tool has been trialled since 2018 through various evaluative methods. One of the measurements for success is the cultural assessment score. HBH has improved its average score from 221 in April 2018 to 268 in March 2019.</p>
<p>Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>CI</p>	<p>HBH endeavour to be an 'employer of choice' and aims to keep improving working conditions for all staff. For example, since the previous audit they introduced changes to sick leave entitlement by allowing staff to take sick leave from their first day of employment and to allocate additional sick leave if an illness was contracted from the workplace.</p> <p>The success of their staff retention initiatives is proven as follows:</p> <p>1) A study carried out by the NZ Age Care Association in 2017 revealed that the total of NZ age care providers (who responded to their survey), had a total staff turnover of 27%, whereby HBH had a total staff turnover of 15% for the same time period. The NZACA survey showed a 38% turnover in RNs, compared to HBH who had a 20% turnover of RNs. Caregiver turnover of survey participants was 27% compared to HBH with 20% turnover. Turnover rates will be compared again when NZACA release their 2018 figures.</p> <p>2) Staff retention is also measured by the length of</p>	<p>Howick Baptist Healthcare are achieving ongoing success with retaining its staff, and in particular, their RNs.</p>

		<p>service at HBH. Currently there are seven staff who have been employed for more than 30 years, seven staff for 25 to 29 years, six staff employed for 20 to 24 years, 15 staff for 15 to 19 years, 23 staff for 10 to 14 years, 44 staff employed for five to nine years and 58 staff employed for less than five years. Approximately 75% of staff stay employed for more than five years.</p> <p>Results of family and resident satisfaction surveys consistently score high satisfaction for how well the staff know each resident. This was confirmed by feedback from residents and their families interviewed. All of the staff interviewed demonstrated in depth knowledge about individual residents, in particular their like and dislikes, routines, capabilities and limitations.</p>	
<p>Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	<p>CI</p>	<p>The service is managed and led by an experienced director of nursing who has developed and implemented a comprehensive assessment process and care planning inclusive of evaluation, review and discharge documentation across the organisation. Staff records were sighted and reviewed. All registered nurses and enrolled nurses are trained to perform these comprehensive assessments and six are specifically trained to perform interRAI assessments and the care planning which was observed to be of a high standard and understood by the staff interviewed. Associated documents are also understood by the caregivers to guide them when performing the personal cares for each individual resident. The multidisciplinary team, some of whom were interviewed such as the enrolled nurses, team leaders, the Eden coach, occupational therapist are all involved in the multidisciplinary team approach to service delivery.</p>	<p>A continuous improvement rating is made for achievement beyond the expected full attainment for the high standard of documentation for managing each stage of service delivery. The clinical medical and nursing records are audited as part of the internal audit system implemented. Previously the records did not always evidence the Eden philosophy and initiatives being embedded into the assessment and care planning process to the extent that is reflected currently. This was an identified area of improvement. The contracting of the Eden coach has reconfirmed how this is beneficial for guiding the caregivers and care partners in the planned care and activities for each individual resident. After a sample of records were reviewed and findings analysed the outcomes recorded evidenced a high standard being maintained. The assessment process and use of recognised assessment tools for pressure injury, wound care, skin integrity and ascertaining falls risk are well implemented as part of the quality improvement programme and evaluated on a regular basis with positive outcomes. Education is provided to staff at all levels to ensure a high standard is achieved and service provision</p>

			is managed competently and promotes safety at all times for residents.
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	CI	<p>The service is coordinated professionally and promotes continuity in service delivery for all residents. This is achieved by a multidisciplinary team approach. However, it was observed and discussed during the audit that the increase in acuity of residents admitted for hospital level care was increasing. Staff had identified this as an area identified for continuous improvement. As per the interRAI statistics the changes in health, end stage disease, signs and symptoms score (CHESS) was above the national and regional average. Graphs, cap triggers from the interRAI assessments performed on residents during the admission process and comparisons with other services were made available. This scoring methodology was indicative of how unstable a resident's condition could be and the higher risk for further decline in condition that would occur. This CHESS score 'serves as an outcome where the objective is to minimise problems to declines in function, or as a pointer to identify persons whose conditions are unstable'.</p>	<p>A continuous improvement rating is made for achievement beyond the expected full attainment for the extensive therapy implemented for over 66 hospital level care residents each month averaging around 350 plus treatments. The service has a dedicated physiotherapist room with a range of rehabilitation and strengthening equipment being available to maintain and improve the physical activity levels of hospital level residents. The physiotherapist interviewed explained the services and programme provided. The programme is an integrated part of the multidisciplinary team approach of resident centred care incorporating the Eden Alternative philosophy. Howick Baptist Hospital (HBH) has five designated physiotherapist assistant roles (50 hours total a week) to assist the physiotherapist who is employed 20 hours per week to execute the programme from Monday to Friday. There is an occupational therapist who works Monday to Thursday from 9am to 4pm who liaises closely with the physiotherapist to provide optimal mobilization. The physiotherapy room was observed in action. All staff in the physiotherapy department, hospital level residents, families and staff have been involved with this project. Evaluation/outcomes identified in the interRAI data evidences that the residents in HBH are unstable and more prone to decline than the national average but the triggers for ADLs and falls have decreased and are still lower than the national average.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated</p>	CI	<p>HBH adopted and implemented the Eden Alternative four years ago with commitment of management and the Board. The Eden Alternative has many benefits for staff, residents and family/whanau. The aim was to embed the</p>	<p>A continuous improvement rating is made for achievement beyond the expected full attainment for the activities programme (social calendar) development including Eden principles. An Eden coach was employed</p>

<p>to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>Eden Alternative philosophy of addressing loneliness, helplessness and boredom and to improve the wellbeing of the residents. In addition, this facility becomes the residents' home. The residents were observed participating in and contributing to various activities in each community visited. The residents were active and engaged and enjoying themselves and staff were fully involved in the activities as well. The Eden coach was available throughout the audit and explained the principles of the Eden Alternative and principles to be attained and embedded within the communities and the organisation at large. Evaluation of progress had been completed throughout this journey and improvements identified on a regular basis. A review of resident's individual activity programmes and evaluations completed led to an area identified for continuous quality improvement being to create more meaningful and purposeful resident-led goals towards their individual programme and Eden growth plan in line with Ministry of Health (MoH) requirements and Principles 1, 5, 6 and 8.</p>	<p>by HBH to assist with mentoring and growth of the activities team and depth of the programme and to review resident participation towards the 'Edenising' process. Regular team meetings and idea sessions with the OT, Eden coach and activities team, Eden resident representatives, families, residents and volunteers from all communities were held. Titles were changed with CEO backup. A new social calendar was introduced on a monthly basis incorporating Eden growth of spontaneity and variety and increased opportunity for spontaneous events, to give care and facilitate care balance. A monthly theme was introduced. Feedback from residents was sourced at every opportunity and evaluations of progress made. The outcome has been very positive, and the Eden Alternative has significantly grown with staff, family and resident-led participation being evident. More staff and residents have been empowered. There are increased activities in the weekend with greater spontaneity and variety occurring. The service is very close to achieving full registration in all ten Eden principles.</p>
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End of the report.