Knox Home Trust Board - Elizabeth Knox Home and Hospital

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Knox Home Trust
Premises audited:	Elizabeth Knox Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 2 October 2019 End date: 3 October 2019
Proposed changes to current services (if any): None	
Total beds occupied across all premises included in the audit on the first day of the audit: 192	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Elizabeth Knox Home and Hospital provides rest home and hospital level care and care for younger people with a disability for up to 199 residents. The service is operated by the Knox Home Trust and managed by a chief executive officer (CEO) with a care leader responsible for clinical care. There have been no significant changes to the service and facilities since the previous partial provisional audit for the new Puriri Home in May 2019, with the first residents moving into this area in July 2019. The organisation continues to be a national leader in the Eden Alternative

with a commitment to resident-directed care and a non-hierarchical management structure. Residents and families spoke positively about the care provided.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, and a general practitioner.

This audit has resulted in areas requiring improvement relating to timeliness of care and documentation, evaluation and trending of quality improvement data and that there are records indicating that all staff have completed the required training. The areas identified as requiring improvement from both the certification and partial provisional audits have been addressed.

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.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to external interpreting services if required, although the very multicultural team of staff and volunteers can assist in most cases.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.	 	Some standards applicable to this service partially attained and of low risk.

The quality and risk management system includes collection of a range of quality improvement data which is reported to staff at meetings. Staff are involved and feedback is sought from residents and families through weekly meetings with the CEO. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

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

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Multidisciplinary team members, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, reflect the Eden philosophy the organisation follows, are based on a comprehensive range of information and accommodate new problems that might arise. Files reviewed demonstrated that there are established timeframes for review and evaluation of the care provided and of residents' needs.
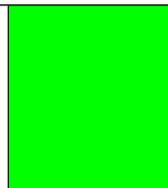
A diverse range of activities are available within a planned programme. Residents are also assisted to pursue other options according to personal choices. Opportunities include individual and group activities. Leisure and lifestyle staff assist residents to maintain their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

Food services provided cover multiple options, meet the nutritional needs of the residents including those with special needs. Personal preferences are also catered for. The food and the kitchen environment are managed according to a food control plan. Residents verified satisfaction with the meals.

Safe and appropriate environment

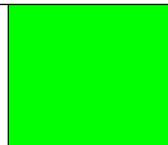|		
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer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

There was a current building warrant of fitness. The certificate of public use for the new Puriri building was sighted as was documentation of testing of hot water temperatures. External areas and handrails are safe and meet the needs of the residents in that area. The fire evacuation plan is current and fire evacuation drills have been completed. The call bell system is effective, and response is timely.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.	████	Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. Thirty-three enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests.   Seventeen restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

The infection prevention and control programme, led by a trained infection control coordinator, includes the surveillance of infections. Surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	2	1	0	0
Criteria	0	39	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The issues, concerns and complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The complaints register and related documentation reviewed showed that 65 complaints have been received between May 2018 and July 2019. Further analysis and trending of this complaints data is needed and was planned (refer criterion 1.2.3.6). Three complaints reviewed in detail showed that actions taken, through to an agreed resolution, were documented and completed within the required timeframes of the Code. Action plans showed any required follow up and improvements have been made where possible. The quality & wellbeing leader oversees complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.
Standard 1.1.9: Communication Service providers communicate	FA	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 evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Four examples of open disclosure/communication following incidents/events were reviewed and discussed with the quality & wellbeing

effectively with consumers and provide an environment conducive to effective communication.		leader and showed an effective process.
		Staff knew how to access interpreter services, although reported this was rarely required due to the large number of staff and volunteers available who can speak different languages.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The strategic plan (2016 – 2021), which is reviewed yearly, outlines the vision, mission, values and goals of the organisation. A sample of reports to the board, which meets six-weekly, was reviewed showed adequate information to monitor performance is reported including the minutes of the care quality meetings, health and safety matters, a report from the CEO and reports from each of the board sub-committees (finance, investment, planning and quality & risk), resident and family meeting minutes, occupancy, staffing and risks, for example. The service is managed by a CEO who holds relevant qualifications and has been in the role for many years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CEO confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at local DHB and other aged care forums. Ongoing national and international links in relation to the Eden Alternative continue. The service holds contracts with Auckland DHB for aged related residential care (ARRC) for hospital and rest home residents and with the Ministry of Health for younger people with a disability (YPD). At the time of audit there were 192 residents with 124 hospital residents, 21 under 65 hospital residents, 34 rest home residents and 2 rest home under 65 residents. There were 7 residents under chronic health contracts, 1 private paying resident, 1 ACC resident, 1 resident under a carer support contract and 1 resident under a short term under 65 hospital contract.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement	PA Low	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a range of topic specific regular satisfaction surveys, and monitoring of clinical outcomes through 'QPS' benchmarking. The quality programme is overseen by the quality & wellbeing leader who has oversight of quality, health & safety and training. There is also a manager of projects who supports a range of quality and development work and projects. The operation and quality plan for 2019 guides activities. Meeting minutes reviewed confirmed regular review of quality indicators and that data and other information is reported and discussed at the clinical quality meetings and leadership team meetings. However, with some exceptions, it was not evident that data was being adequately analysed to monitor trends over time. Staff reported their involvement in quality activities through audit, 'quality circle' meetings where improvements are discussed, their involvement with the Eden Alternative work and review of the clinical quality meeting minutes. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are

| principles. | | completed regularly with a more recent focus around specific relevant topics, for example the 'First Impressions' survey sent to all new residents over the past year to assess the fulfilment of the 'Welcome Promise'. Improvements and resurveying is in progress. All residents and family members interviewed during the survey were very happy with the care and services at Elizabeth Knox Home and Hospital.

Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.

The CEO was well versed in risk management including the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk register was reviewed and was current, last being updated on the 24 September 2019. The quality & wellbeing manager was familiar with the Health and Safety at Work Act (2015) and requirements. |
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| Standard 1.2.4: Adverse Event Reporting

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the care & quality forum and the board. Two events that were reported through the DHB risk reporting system and notified to Elizabeth Knox Home and Hospital were reviewed in detail and showed a thorough investigation and follow through of corrective actions.

The quality & wellbeing leader described essential notification reporting requirements, including for pressure injuries. They advised there have been notifications made to the MoH in relation to two pressure injuries, an RN nursing shortage and seeking support in relation to a resident. There have been three notifications to public health for infection outbreaks, and two notification to the police and MoH (pertaining to one resident/relative issue). There have been no coroner's inquests or issues-based audits. |
| Standard 1.2.7: Human Resource Management

Human resource management processes are | PA Low | Human resources 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. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented. The quality and wellbeing leader and the care leader confirmed processes. The volunteer coordinator confirmed that employment of the around 900 volunteers a year is also systematic and thorough process including interview, referee checking and orientation. Random police vetting of 10 |

conducted in accordance with good employment practice and meet the requirements of legislation.		percent of volunteers occurs every two months.
		Staff and volunteer orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a yearly performance review.
		Continuing education is planned on an annual basis, including mandatory training requirements. The programme for 2019 was sighted. Thirty-six staff are engaged in the Careerforce programme at the time of audit, ranging from levels 2 to levels 4. Other staff are engaged in the regular training sessions which included restraint minimisation and use, fire and safety, continence assessment and care planning, health and safety, last days of life pathways, EPOA and informed consent, abuse & neglect, cultural safety and moving and handling, for example. An end of year education report showed that a wide range of options are available for staff in all roles. Training records are held in three different places/electronic systems and it was difficult to determine if all staff have completed all requirements.
		There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments, although the service was aiming to increase the numbers trained.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing is based around each of the nine 'homes' with the aim of providing a consistent team for each home. Each home has an RN in the morning for the 20-25 residents in the home. There are eight RNs on the afternoon shift and four RNs overnight. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them and that a team approach is used. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All but five RNs have a current first aid certificate.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative	FA	The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed in different areas on each of the two days of audit demonstrated good knowledge and had a clear understanding of their roles and of the responsibilities related to each stage of medicine management. All staff who administer medicines, which includes all registered nurses and some senior care partners, have a current

requirements and safe practice guidelines.		competency to perform the functions they manage.
		Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These are checked against the prescriptions by two persons with at least one being a registered nurse. All medications sighted in the sample checked were within current use by dates. Clinical pharmacist input is provided most months when controlled medicines are delivered and on request.
		Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.
		The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.
		Prescribing practices of medicines are consistent with the expectations of best practice and the electronic system in use. The required three-monthly GP review was consistently recorded on the electronic medicine record. Since commencement of the use of an electronic medicine management system, standing orders are no longer used.
		There is one resident who is self-administering some of their medicines. The GP is required to sign off the person's competency at least every three months. Appropriate oversight by the nursing staff ensures this is managed in a safe manner.
		There is an implemented process for comprehensive analysis of any medication errors via the incident and accident reporting system through to the quality and risk management system.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Food services are provided on site by an external contractor and food provided is in line with recognised nutritional guidelines, as approved by a dietitian for its appropriateness for the range of service users at Elizabeth Knox Home and Hospital. The menu goes over a six-week rotational cycle that follows summer and winter patterns and was appraised by a qualified dietitian, May 2019. Each day, residents are provided with three options including a vegetarian option plus a dessert and mid-day and two options for the evening meal with fresh fruit.
		All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by a relevant authority May 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.
		A nutritional assessment (dietary requirements and special requests) is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Kitchen staff liaise with individual residents to ensure special needs are accommodated and after the mid-day meal the cook goes out to the

		residents to discuss the food provided. Special equipment, to meet resident's nutritional needs, is available.

Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.6: Service Delivery/Interventions

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Elizabeth Knox Home and Hospital continues to operate according to the Eden Alternative. The residents are at the centre of all actions as is community integration. Documentation, observations and interviews verified that care provided to residents was consistent with their personal preferences, individualised needs, goals and the care plan. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision and in lifestyle and leisure programmes. A focus on rehabilitation enables residents to strive to improve their functioning where this is practicable and to maintain their abilities when this is realistic. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, care is consistently of a very high level and there are not really any concerns. The staff turnover and the impact of this was noted by the GP. Care partners confirmed that care is provided as outlined in the documentation and according to the instructions of registered nurses, doctors and allied health professionals. A range of equipment and resources was available, including a gymnasium area, outdoor garden environments, and access to activities and transport. Equipment and resources required for service delivery interventions for the varied levels of support provided is available and residents' needs are being met. |
| Standard 1.3.7: Planned Activities

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is planned and coordinated by a lifestyle and leisure community engagement leader who is supported by two full time and three part time activities assistants alongside several hundred rostered volunteers. Weekly diaries that describe some of the more structured options are distributed. Examples sighted reflected some of the residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events were integrated with options including games requiring both physical and cognitive skills, shopping for necessities and for pleasure, external and in-house entertainment, activities that address a range of spiritual and cultural needs and those requiring creative approaches or ways to relax. Multiple spontaneous opportunities are also responded to and examples of these included responding to baby animal feeding needs (chickens and lambs), visits from school students and a visit to an internet café. Staff were observed making every effort to respond to residents' expressions on a day to day basis. Celebration of special events included for international day of the elderly, Fathers' day and preparations for a ball the day after the audit were under way.

A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Attendance records are kept and assist with ongoing activities planning, as does casual feedback and residents' meetings. Progress notes specifically for lifestyle and leisure are written for each person most months. Although each resident's activity needs are to be evaluated as part of the formal six-monthly care plan |

		review and multi-disciplinary reports to ensure the activities available are meaningful to the residents there have been delays in this occurring as noted in standard 1.3.3.3.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and consistently reported in the progress notes. If any change is noted, it is reported to the registered nurse and there were multiple examples of this evident. Formal care plan evaluations are scheduled to occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service would normally respond by initiating changes to the plan of care. As identified in the corrective action for 1.3.3.3 this is not always happening within the expected timeframe, therefore has been raised for corrective actions under that criterion. Also, a corrective action raised in a previous partial provisional audit in relation to the need for multi-disciplinary reviews to be undertaken within required timeframes have been addressed within that corrective action as the problem persists. With reviews and evaluations not occurring within a timely manner, the consequence is that long term care plans are not always being added to and updated to reflect changes and this has also been included in 1.3.3.3. Examples of short-term care plans being reviewed, and of progress evaluated as clinically indicated, were noted for infections and wounds. Residents and families/whānau interviewed provided examples of their involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness (expiry 28 September 2020) was sighted. The Certificate of Public Use for Puriri (the new building) was sighted with an expiry date of 17 January 2020. Records of regular testing of the water temperatures in residents' areas were sighted and meet safety requirements. External deck and pathway areas have been completed and handrails installed in the Puriri area. All previous areas identified at the partial provisional audit were confirmed as being addressed and safe.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response	FA	Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in July 2014. The approval letter for the Puriri evacuation plan was sighted (dated 23 July 2019) and the fire evacuation completed 22 July 2019,as attended by the fire service, showed this was well completed within three minutes and 47 seconds. The orientation programme includes fire and security training. The previous areas for improvement for Puriri have been addressed.

during emergency and security situations.		Call bells alert staff to residents requiring assistance. The call system in Puriri is fully installed with response times monitored showing prompt response.
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	Infection surveillance, as described in the infection prevention and control policies and procedures and during interview with the infection prevention and control coordinator, is appropriate to that recommended for long term care facilities. The service provider is now using the McGreer definitions to guide the surveillance processes. Infections are documented as they arise and the infection prevention and control coordinator reviews all reported infections against other information sources such as laboratory results. New infections and any required management plan, as directed from a registered nurse of a GP, are discussed at handover to ensure early intervention occurs. Monthly surveillance data is collated, and senior staff reported that analysis of any trends, possible causative factors and required actions is undertaken. However, records of these processes were only available until February 2019. Although individual infections are being well managed, ongoing data is documented and QPS benchmarking has been occurring, there is limited evidence other than verbal reports, of analysis of the data and of subsequent identified actions at the organisational level. This has been raised for corrective action under criterion 1.2.3.6 alongside other aspects of quality management requiring analysis and relevant follow-up action. A report following a debrief on a recent gastroenteritis outbreak affecting two of the houses was reviewed and demonstrated a thorough process for investigation and follow up. The event identified two key required actions including the need to ensure new staff are more effectively updated on outbreak management protocols and that improved communication processes are instituted for advising of such situations. These are progressively being incorporated into practice.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator interviewed provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. On the day of audit, 17 residents were using restraints and 33 residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. Staff interviewed were clear about the difference between a restraint and an enabler. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes and from interviews with staff. Further analysis of restraint data is required (Refer

		criterion 1.2.3.6).

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Various quality improvement data is being collected including complaints, incidents, infections, restraint use, and health and safety. While there has been periods of graphing trends and analysis since the previous survey, at the time of audit there was a lack of analysis of data. This included identification of themes, trends and evaluation in relation to complaints, incidents, restraint and infection surveillance. Raw data (numbers) only is being reported to the care quality and other forums. A report related to health and safety was reviewed which showed trending of data over a three-year period – to the end of 2018. QPS benchmarking data for the quarter April – June 2019 was available; however, formal analysis and development of improvements plans was not evident.	There was a lack of analysis of quality improvement data. This included identification of themes, trends and evaluation in relation to complaints, incidents, restraint and infection surveillance. Raw data (numbers) only is being reported to the care quality and other forums.	Quality data collected is analysed, evaluated and where appropriate trended over time and these results communicated to staff and where appropriate residents and families.

				180 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Staff feel well supported by training opportunities available. Mandatory/required training is defined, and a training calendar developed which includes a broad range of mandatory and non-mandatory topics. However, there is no systematic approach to record and identify that all staff have completed training as required. Records are held for individual staff members, within the TimeTarget, ACCESS data base and on a spreadsheet. None of these records contained a full record to assure the organisation that requirements are being met. Personnel files did not include full records of training completed by each staff member. The performance review process does not record that training requirements are checked as part of that process and the individual TimeTarget records did not indicate that all requirements have been met. Staff interviewed could identify a range of training they had completed in the past year.	There is no one recording system to establish that all staff have completed the required training.	Develop a system that will record all training completed by staff that will assure the organisation that mandatory requirement have been met. 180 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Service provision is of a high standard and residents are being provided with good quality lifestyle opportunities. However, not all aspects of service provision including assessment processes, care planning, evaluation and reviews are being provided within expected time frames. Long-term care plans are to be developed and entered into V-Care within three weeks of admission; however, this has not always been occurring over recent months and some key interventions including use of a CPAP machine were not documented. Likewise changes in mobility and nutritional requirements for example were not all captured as updates to care plans. Reassessment outcomes are intended to inform the evaluation processes; however, there were examples in the files sampled of this not occurring, or a specific assessment such as interRAI being completed after the evaluation. Six monthly care plan evaluations and annual multi-disciplinary reviews are currently being extended out due to the shortage of nurses, therefore many were overdue. Other than monthly entries into progress notes, formal reviews of lifestyle and leisure plans have not occurred.	Over half of the files reviewed had one or more stages of service provision documentation (planning, evaluation and review) overdue for review and/or update. • New resident interRAI assessments and long-term care plans are not all being completed within the timeframes as required by the ARRC agreement • There were examples of interRAI reassessments and	Each stage of care planning, provision, assessment and review are completed within timeframes that meet policy and contractual requirements to ensure the needs of the residents are met in a safe manner. 90 days

			care plan updates that have not been undertaken within the required six-month timeframe	
			• Not all care plans accurately reflect the current status of the respective resident	
			• There were examples of long-term care plans being developed or reviewed prior to the interRAI assessment or reassessment	
			• A number of six-monthly care plan reviews and evaluations are overdue. Multi-disciplinary team reviews are not all being completed annually as per Elizabeth Knox policy and contractual expectations and leisure and lifestyle reviews.	

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.

No data to display

End of the report.