St Josephs Home of Compassion Heretaunga Limited - St Josephs Home of Compassion

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 Health and Disability Auditing New Zealand 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:	Saint Joseph's Home of Compassion Heretaunga Limited
Premises audited:	St Josephs Home of Compassion
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 24 August 2020 End date: 25 August 2020

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: 84

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

St Joseph's Home of Compassion is owned and operated by The Sisters of Compassion and overseen by a board of directors. The facility is certified to provide rest home, hospital level (geriatric and medical) and dementia care for up to 88 residents. On the days of audit there were 84 residents

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff, management and the general practitioner.

St Joseph's Home of Compassion has a fully implemented quality and risk system. The service is managed by an experienced manager who is supported by a clinical nurse manager, an assistant manager and two unit coordinators. Residents and family interviewed spoke positively about the service provided.

No shortfalls were identified during this certification audit. The service has been awarded a continuous improvement around reducing the incidence of pressure injuries and skin tears.

Consumer rights

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

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and their families are involved in care decisions. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines established by 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.		Standards applicable to this service fully attained.

Services are planned, coordinated and are appropriate to the needs of the residents. The manager is responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management

programme is in place. Data is collected, analysed, discussed and changes made as a result of trend analysis. Quality improvement plans are developed when service shortfalls are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

Registered nursing cover is provided twenty-four hours a day, seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

Continuum of service delivery

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

There is an admission package on all services and levels of care provided at St Joseph's Home of Compassion. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and develops the care plan with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six monthly. Resident files included the general practitioner, specialist and allied health notes.

Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers responsible for administration of medicines complete annual education and medication competencies. The electronic medicine charts reviewed meet prescribing requirements and were reviewed at least three monthly.

A diversional therapist and assistant manager/registered nurse oversee the activity team and coordinate the activity programme for the rest home, hospital and dementia level of care residents. The programme includes community visitors and outings,

entertainment and activities that meet the individual recreational, physical and cognitive abilities and preferences for each resident group. Residents and families reported satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are prepared and cooked on site by a contracted service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are nutritious snacks available 24 hours.

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 are documented processes for the management of waste and hazardous substances in place. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with ensuites or access to communal facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Systems and supplies are in place for essential, emergency and security services. All registered nurses hold a current first aid certificate.

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.

Staff regularly receive education and training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator. Seven residents were using restraints and no residents were using enablers at the time of audit.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	49	0	0	0	0	0
Criteria	1	100	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Saint Joseph's Home of Compassion policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training around resident rights at orientation and as part of the annual training/education programme. Interviews with staff (five caregivers, four registered nurses (RNs); including two-unit coordinators, two kitchen staff, two housekeepers, one cleaner two laundry staff and one activity person) confirmed their understanding of the Code. Three managers interviewed (the manager, the assistant manager and the clinical nurse manager) also confirmed their understanding. Five residents (four rest home level and one hospital level) and eight relatives (four hospital level, and four with family in the dementia unit) interviewed, confirmed that staff respect privacy and support residents in making choices.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau	FA	There are established informed consent policies/procedures and advanced directives. Ten resident files were reviewed (four hospital including one resident under chronic medical illness contract (CMI) and one respite care. Three rest home residents including one under long term stay – chronic health condition contract (LTS-CHC) and three dementia level of care residents) and included general consents and for photographs. There are specific consents for wound photographs, influenza vaccinations and other

of choice are provided with the information they need to make informed choices and give informed consent.		specific treatments. Advance directives for acute care and continuing care such as antibiotics and hospital admissions were completed and on the resident files. Resuscitation plans were sighted in all files and were signed appropriately. Where residents had been deemed incompetent the GP had signed a medically indicated not for resuscitation form in discussion with the enduring power of attorney (EPOA). Copies of EPOA were present in resident files. The EPOAs for three dementia care residents files reviewed had been activated. An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers and registered nurses interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. All residents' files reviewed had signed admission agreements on file. A short-stay admission agreement was in place for the respite care resident.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. The pastoral care coordinator and chaplain are identified by staff and residents as an advocate. The resident files included information on residents' family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the second day of audit when the Covid 19 level was lifted. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed were

make a complaint is understood, respected, and upheld.		able to describe the process around reporting complaints. A complaint register includes written and verbal complaints, dates and actions taken. Five complaints from 2019 and four complaints year to date 2020 all document that complaints have been managed in a sympathetic and timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in management and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is an information pack given to prospective residents and families that includes information about the Code and the Nationwide Advocacy Service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The information pack is discussed with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.
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	A tour of the premises confirmed there are areas that support personal privacy for residents. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff demonstrate sensitivity in regard to resident privacy and dignity and where possible, encourage the resident to be involved in their care according to their ability. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with caregivers described how choice is incorporated into resident care.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and	FA	The sisters of compassion have developed strong links with Māori. The home has links with local Māori iwi and a local marae. A Māori health plan policy for the service has been documented. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. The were no residents who identified as Māori.

acknowledges their individual and cultural, values and beliefs.		
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out and the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plans. Cultural interventions were individualised and documented well in the care plan of a resident who did not identify as NZ European. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities. The two monthly full facility meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries. Caregivers from the dementia unit described how they build a supportive relationship with each resident. Interviews with four families from the dementia unit confirmed the staff assist to relieve residents' anxiety.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available 7 days a week, 24 hours a day. General practitioner (GP) visits to the service are twice a week and provides an after-hours service. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The GP interviewed is satisfied with the level of care that is being provided. Physiotherapy services are provided by two registered physiotherapists providing four hours a week of physiotherapy service between them. A dietitian is also available for urgent consultations. A podiatrist is on-site monthly and a music therapist weekly. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent. The service has reduced the incidence of pressure areas and skin tears.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 15 incident reports reviewed for June and July 2019 met this requirement. Family members interviewed confirmed

provide an environment conducive to effective communication.		they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. Specific information around the dementia unit is available to all family members.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	St Joseph's Home of Compassion is owned and operated by The Sisters of Compassion and overseen by a board of directors. The facility is certified to provide rest home, hospital level (geriatric and medical) and dementia care for up to 88 residents. On the days of audit there were 84 residents. Twenty one residents were receiving rest home level care (including one funded through the Long Term Supports – Chronic Health Conditions - LTS-CHC - and one respite resident), forty seven were receiving hospital (including two funded through the LTS-CHC contract, one respite and one funded through the Chronically Medically Ill contract – CMI) and 16 residents cared for in the dementia unit. All other residents were on the age-related care contract (ARCC). There is a quality improvement plan documented for 2020 and a strategic plan based on the service's vision and mission. St Joseph's Home of Compassion is managed by an experienced manager who is a registered nurse (RN) and who has been in the role for 19 years. She is supported by an assistant manager (also an RN) and a clinical nurse manager who is new to the role. The manager, assistant manager and clinical nurse manager have maintained at least eight hours of professional development activities related to managing an aged care facility.
Standard 1.2.2: Service Management 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.	FA	The assistant manager and clinical nurse manager cover during the temporary absence of the manager.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an	FA	An established quality and risk management system is embedded into practice. Quality and risk performance is communicated to the board through board reports as well as at least weekly telephone calls.

established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		Quality information is reported across two monthly quality meetings, staff meetings, and clinical care meetings. Discussions with the managers and staff reflected staff involvement in quality and risk management processes. Resident meetings are held three monthly, and minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. A resident/relative survey was distributed in January 2020 and overall feedback was 85- 93 % satisfied. Following feedback from the survey, an action plan was documented and evidences that issues were followed up and resolved. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed by the service at least two yearly. Clinical guidelines are in place to assist care staff. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data. This is utilised for service improvements. Action plans from staff quality meetings and reflect actions being implemented and signed off when completed. Health and safety policies are implemented and monitored by the Health and Safety committee. Risk management, hazard control and emergency policies and procedures are in place. A health and safety representative (the manager) was interviewed about the health and safety programme. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Falls prevention strategies are in place including (but not limited to): individual and group exercise programme; meeting individual toileting needs; sensor mats; use of perimeter guard mattresses; increased monitoring; identification and meeting of individual needs.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected	FA	There is an incident/accident reporting policy that includes definitions and outlines responsibilities including: immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports (forms for incidents, accidents, safety and hazard, (FISH forms) are completed for each incident/accident with immediate action noted and any follow-up action required. All incidents are collated monthly and a separate report is documented for each of; falls, skin tears, bruises, pressure injuries and medication errors.

consumers and where appropriate their family/whānau of choice in an open manner.		A review of 15 incident/accident forms (a sample from July 2020) identified that forms are fully completed and include follow-up by a registered nurse. Neurological observations were evidenced to be consistently completed for unwitnessed falls as per policy. The manager, assistant manager and clinical nurse manager and senior registered nurses are involved in the adverse event process. The manager was able to identify situations that would be reported to statutory authorities. There have been no notifications needed. One gastroenteritis outbreak was notified to public health 2019.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are a range of human resources policies in place. Ten staff files reviewed (four RNs including two unit coordinators, one clinical nurse manager, one diversional therapist and four caregivers) included a comprehensive recruitment process including: reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. The orientation programme provides new staff with relevant information for safe work practice. Most training is provided during full day training sessions with additional training provided as needed and incidental training is provided according to identified need and at staff request. There is an attendance register for each training session and an individual staff member record of training. All caregivers who work in the dementia unit have completed the required dementia standards. Registered nurses are supported to maintain their professional competency. There are implemented competencies for registered nurses. The home provides palliative care services and works closely with Te Omanga Hospice. Palliative care training is provided to staff. Registered nurses are supported to maintain their professional competency. Five of 15 permanent registered nurses have completed their interRAI training with a further two in training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A policy is in place for determining staffing levels and skills mix for safe service delivery. The manager and clinical nurse manager are all on duty Monday to Friday. The assistant manager works four days a week. There is an RN unit coordinator for the dementia unit, one for the rest home and the Clinical Manager runs the hospital wing. There is between two and three RNs on duty each AM, and for each PM and one on each night. The RNs

		are allocated between the three units. The dementia unit has 16 beds with 16 residents on the days of audit. There are two caregivers (full shifts) for the AM shift and either one half shift or a full time RN and two full shifts for the PM and one half shift. There is one caregiver for nights with additional support for the hospital or rest home as needed. The rest home wing has 23 beds with three hospital residents and 20 rest home on the days of audit. There are two caregivers for the PM and for the AM shift and one on nights. There is also a Registered Nurse on the morning shift and afternoon shift covered by the hospital area RN. The hospital wing has 49 beds, on the days of audit there were 44 hospital residents and one rest home level. There are five full shift caregivers and five half shifts for the AM shift and four caregivers on a full shift and two on a half shift for the PM. There are two caregivers for the night shift. Staff working on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Individual resident files demonstrate service integration.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Families and prospective residents are invited to visit the facility even before confirming admission. Pre-admission information packs including information on the dementia care service is provided for families and residents prior to or on admission. Ten admission agreements for residents were signed and aligned with all contractual requirements. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.		involved for all exit or discharges to and from the service. All transfer documentation is kept on the resident files.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. Medications are stored securely in all three wings. Registered nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Registered nurses complete syringe driver training. Education around safe medication administration has been provided. Standing orders used for hospital level residents were current and met the legislative requirements. The hospital level stock is checked regularly for stock levels and expiry dates. Regular medications are delivered in robotic rolls with the 24 hours of medications and these are checked by an RN. Any discrepancies are fed back to the supplying pharmacy. There were no residents self-medicating on the day of audit. All eye drops are dated on opening. The medication fridge is monitored daily with corrective actions evident for temperatures outside of the acceptable limit. The medication room air is monitored and recorded daily. The service uses an electronic medication system for long-term residents. Nineteen electronic medication charts and one paper-based medication chart (respite care) reviewed, met legislative prescribing requirements. 'As required' medications are authorised by the RN on duty. The effectiveness of 'as required' medications are documented in progress notes and the electronic system. The GP has reviewed the medication charts three monthly. Internal medication audits are completed and results reported to RNs and care staff.
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	A contracted service provides meals and home baking at St Joseph's Home of Compassion. The area manager and site manager (both qualified chefs) were interviewed. The site manager/chef is on duty from 7 am – 2 pm and is supported by a catering assistant 11 am to 6 pm. All food services staff including the home assistants (employed by the home) have completed food safety and chemical safety training. The six weekly seasonal menus have been reviewed by a registered dietitian last in July 2020. The main meal is at midday. The menu includes a vegetarian option and pureed meals. Resident preferences and feedback are considered when reviewing the menu. Special dietary requirements are provided, including gluten free. Food allergies and dislikes are accommodated. The chef receives diet profiles for each resident which is updated with any changes. Meals are delivered to each wing in a bain marie and served by the care staff. Special diets are plated and labelled in the kitchen. Each wing has a functioning satellite kitchen with fridge, stove, dishwasher, pantry and crockery. Home assistants prepare and serve breakfasts, morning and afternoon teas and supper. The fridges are monitored daily and the dishwashers serviced regularly by an external contractor. There were adequate

		fluids and smoothie drinks sighted in the fridges and food and snacks available. There were nutritious snacks and foods available in the dementia wing including biscuits, yoghurts, fruit, sandwiches and ice-cream. The food service has a food control plan which expires January 2021. The service uses a Safe Pro computer-based system to record daily temperatures for fridges, chillers, freezers, inward goods, end cooking food temperatures and probe calibrations. All foods were stored correctly and date labelled. Chemicals were stored safely. Cleaning schedules were in place and had been completed daily. The food service receives direct feedback and input from resident meetings on the meals. A recent food survey completed by the Home resulted in 90% food satisfaction. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	There is an admission information policy. The reasons for declining entry would be if the service were unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN completes an initial assessment on admission including risk assessments for falls, pressure injury, pain, continence and other assessments as relevant. Behavioural assessments are completed for all residents with diagnosed dementia. An interRAI assessment is undertaken within 21 days of admission and six monthly, or earlier due to significant health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others and allied health professionals as relevant. InterRAI assessments, assessment notes and summary were in place for all long-term resident files reviewed including the CMI and LTS-CHC residents. The long-term care plans in place reflected the outcome of the assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote	FA	Resident long-term care plans reviewed were resident-focused and individualised. Identified support needs were included in the care plans for all resident's files reviewed. A short-term respite care plan was in place for the respite care resident. The three files of residents in the dementia care unit contained a behaviour management plan that describes the behaviour, possible triggers, early warning signs and prevention/calming interventions. Care plans were developed in consultation with the resident (as

continuity of service delivery.		appropriate) and family/whānau/EPOA. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration and evidence of allied health care professionals involved in the care of the resident such as the GP, physiotherapist, hospice service, podiatrist, district wound nurse, psychogeriatrician and older persons health service. Short-term care plans were in place for short-term needs, reviewed regularly and either resolved or added to the long-term care plan as an ongoing problem.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There is documented evidence on the family/whānau record in each resident file of family notification of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits, care plan reviews and changes in medications. Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds and skin tears (nine hospital residents, two rest home residents and two dementia care residents). There was one rest home resident with chronic venous ulcers and two hospital residents with stage 1-2 facility acquired pressure injuries. There is a range of equipment readily available to minimise pressure injuries. Chronic wounds have been linked to the long-term plans. There was evidence of the DHB clinical nurse wound specialist involvement in the management of the venous ulcers. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, fluid intake, pain (Abbey pain scale), challenging behaviour, wounds, restraint, continence, bowel management, multi-purpose resident monitoring chart (for example resident whereabouts) and two hourly positioning. Registered nurses review the monitoring charts and report identified concerns to the GP, nurse practitioner or nurse specialist. Short-term care plans document appropriate interventions to manage short-term changes in health.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a	FA	The activity team includes one diversional therapist (DT), one DT reliever and two recreational coordinators (one in DT training). The activity team plan and coordinate a monthly activity programme for the rest home/hospital wing and dementia wing. The programmes are signed off by the assistant manager/RN. The activity team rotate through the rest home, hospital and dementia wings providing activities from 10.30 am to 4 pm Monday to Friday and 1.30 to 4.30pm on Saturdays for the dementia unit.

consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		Caregivers implement set activities on the weekends as per the programme in the rest home and hospital. Caregivers in the dementia wing incorporate small group and individual activities as part of their role. Activities take place in the lounges, conservatory, dining rooms and recreational room (located in the rest home/hospital). Many activities are integrated for rest home, hospital and dementia residents as appropriate and under supervision. Integrated activities include weekly entertainment with happy hours and bowls. There are a group of volunteers who help with activities and one-on-one activities. There are adequate resources available. The activity programme for each wing meets the cognitive, intellectual, emotional and physical abilities for the group of residents. There is a theme for each month with activities linked to the theme. Activities include word games, board games, art and craft sessions, colouring, movies sensory time, baking, singing and hand and nail care. Tai Chi is offered weekly in the rest home/hospital. Reminiscing, dancing and household tasks is included in the dementia wing programme. Outdoor resident walks and gardening are weather dependent. A music therapist provides therapy four hours a week for dementia care residents. There is skype available and sky sports available in one of the TV lounges. Community visitors (outside of lockdown) included volunteers, musical therapy university students, college students, pre-school children, canine friends and fortnightly visiting “pop up” library and Mr Whippy ice-cream van. Residents attend community events such as the annual council concert, movies, cafés and other places of interest. There are fortnightly scenic drives and outings. Special events and festivities are celebrated and families are invited to attend. Residents are supported to attend the daily mass and other religious services. An activity assessment is completed soon after admission for each resident. An activity plan and goals are developed for the resident in consultation with the resident/relative. Activities and recreation are included in the long-term care plan. Dementia care residents have an individual 24-hour activity programme which includes night activities. The younger person under the LTS-CHC contract choses to join in on group activities of interest and enjoys one-on-one time as well as outings with family and friends into the community. Residents and families have the opportunity to feedback on the activity programme through meetings and surveys. Residents and relatives spoke positively about the activity programme even through the lockdown period when entertainment and visitors were restricted.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely	FA	All initial care plans reviewed were evaluated by the RN within three weeks of admission in consultation with the resident/relative. Long-term care plans had been reviewed at least six monthly or earlier for any health changes for long-term residents. The written evaluation documents the resident’s progress against identified goals. The GP reviews the residents at least three monthly or earlier if required. The multidisciplinary team includes input from the clinical manager, unit coordinator, DT, physiotherapist,

manner.		pastoral carer, resident/relative and any other allied health professional involved in the care of the resident. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. Changes are updated on the long-term care plans.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place. Chemicals are stored in locked areas throughout the facility. Safety data sheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Personal protective clothing is available in the sluice rooms including gloves, plastic aprons and full-face shields. Staff were observed wearing appropriate personal protective clothing when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training with an approved trainer.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness that expires 28 February 2021. The full-time maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Monthly inspections include call bell testing and hot water temperature monitoring. Temperature recordings reviewed were between 43-45 degrees Celsius. Essential contractors are available 24 hours. Electrical testing is completed annually. An external contractor completes annual calibration and functional checks of medical equipment. The facility has wide corridors with handrails and sufficient space for residents to safely mobilise using mobility aids or for staff to transfer residents in hospital lounge chairs. Furnishings are appropriately placed in communal areas. There is safe access to the outdoor areas. Seating and shade are provided.

		The dementia care wing has secure keypad exit and entry. Residents have free access to the safe outdoor courtyard which has a walking pathway, gardens, seating and shade. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	Toilet and shower facilities are of an appropriate design to meet the needs of the residents. The resident rooms in the rest home wing have ensuites. The hospital rooms have basins. There is a project plan to extend hospital rooms and add ensuites. All resident rooms in the dementia wing have a toilet and hand basin ensuite with shared communal showers.
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	Resident rooms are spacious. There is one double room currently single occupancy. All other resident rooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms as viewed on the days of audit.
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	Communal areas within the facility include separate rest home and hospital dining rooms, main lounge and smaller lounges, conservatory and several seating alcoves. Seating and space are arranged to allow both individual and group activities to occur. A smaller lounge has Sky sports available. There is a separate dining room and three lounge areas in the dementia wing. The outlook from one dementia lounge provides an open view over the neighbouring sport grounds. There is an on-site chapel, library lounge, recreational room and hairdresser room.
Standard 1.4.6: Cleaning And Laundry Services	FA	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry and housekeeping services. There are designated laundry and cleaning staff seven days a week. All linen and personal clothing is laundered on site. The laundry operates from 7 am to 3 pm with two

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		staff on duty, one on the dirty side and one on the clean side of the laundry. There are two doors – one entering the dirty side and the other on the clean side of the laundry. There are housekeepers in each wing seven days a week from 7 am to 3 pm. Trolleys are kept in locked cleaners' rooms when not in use. Chemical bottles are labelled with manufacturer labels and are refilled using a chemical dispensing unit. The housekeepers cleaning trolley used in the dementia unit has a locked chemical box. Four staff interviewed (two laundry and two housekeeping) had completed chemical safety and infection control in-service around outbreak management and Covid 19. All staff could describe the additional precautions and cleaning processes undertaken during lockdown and currently in level 2 restrictions. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes. The chemical provider monitors the effectiveness of chemicals and laundry procedures.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back-up power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. Activities staff also hold first aid certificates. Call bells were situated in all communal areas, toilets, bathrooms and personal bedrooms. Residents were sighted to have call bells within reach during the audit. Where appropriate sensor mats were also observed to be in use. The service has a visitor's book at reception for all visitors including contractors to sign in and out. Appropriate security systems are in place.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and	FA	Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature with a mix of ceiling and radiator heating. There are sufficient doors and opening windows for ventilation. All bedrooms have good-sized windows, which allow plenty of natural light.

comfortable temperature.		
Standard 3.1: Infection control management 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.	FA	St Joseph's Home of Compassion has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A unit coordinator/registered nurse is the designated infection control nurse with support from the infection control team. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. Covid 19 education has been provided for all staff, including hand hygiene and use of PPE. All visitors are required to provide contact tracing information. All new residents are isolated for two weeks.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	A registered nurse/unit coordinator is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (includes a range of staff) have good external support from the local laboratory infection control team, IC nurse specialist at the DHB and Bug Control. The infection control team is representative of the facility. Infection prevention and control is included as part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the St Joseph's clinical committee and have been reviewed and updated.

Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed infection control training through the local DHB and Bug Control. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
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 is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Infections are part of the key performance indicators. Outcomes and actions are discussed at clinical and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible. A Noro virus outbreak during 2019 was managed well and public health were informed.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. St Joseph's Home of Compassion is actively working on reducing restraint and staff interviewed were engaged in meeting this goal. There were seven hospital level residents using restraint (bedrails and lap belts) and no residents with enablers during the audit. Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.
Standard 2.2.1: Restraint approval and processes 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	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (a unit coordinator/registered nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.

this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by an RN in partnership with the GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Two hospital level residents' files where restraints are in use, were selected for review. The completed assessment considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring was evidenced to be consistently documented on the two restraint monitoring records reviewed. A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly and restraint use is discussed monthly at staff and quality management meetings as well at two monthly clinical meetings. A review of two resident files identified that evaluations are up to date. The service provided evidence where evaluation of the need for the use of restraint was evaluated and removal of a restraint was trialled successfully for one resident.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the	FA	The restraint minimisation programme is discussed and reviewed at the annual restraint meetings, two monthly clinical meetings, and two monthly quality meetings. Meeting minutes include (but are not limited to): a review of the residents using restraints or enablers, updates (if any) to the restraint programme and

monitoring and quality review of their use of restraint.		staff education and training.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The service monitors and reviews quality information monthly and documents quality benchmarking reports. Opportunities for improving service and resident outcomes are proactively followed up with action plans. This has resulted in a reduction in the incidence of skin tears and pressure injuries.	Pressure injuries are monitored monthly, this includes all new pressure injuries and the total pressure injures. Quality benchmarking results documented an area for improvement for the service late 2017. The service implemented a process to reduce the incidence. This included training for staff, review of each resident’s individual needs and changes to care. An external provider assisted with education and care reviews. New pressure relieving equipment was purchased as needed. This has resulted in a steady reduction in the incidence of pressure injuries for the service; there were 23 pressure injuries for the six months July to December 2017 compared with 12 in the last six months. The service also noted that skin tears were higher than expected. Again, additional training was provided to staff as well as additional information around manual handling during handovers and discussions around individual resident needs. Clinical meetings gave the reduction of skin tears a high priority. The service purchased skin protectors that are provided as needed. As a result of the interventions, training and high priority given to skin tears, the service has seen a reduction. There were 53 skin tears for the six months July to December 2017 compared with 21 in the last six

			months.

End of the report.