

FOMHT Health Services Limited - Jack Inglis Friendship Hospital

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:	FOMHT Health Services Limited
Premises audited:	Jack Inglis Friendship Hospital
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: 4 May 2021 End date: 5 May 2021
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:	67

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

Jack Inglis Friendship Hospital is governed by a Trust board and provides rest home, hospital, and dementia level of care level care for up to 77 residents. On the day of the audit there were 67 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 a general practitioner.

The chief executive officer is well qualified and experienced for the role and is supported by a clinical manager and two clinical nurse leaders. Key improvements since the last audit have included the development of an engaged and effective leadership team, a restraint free environment and a revamp of the brand with the service now called Jack Inglis Care Home with the logo and website refreshed accordingly. Residents, relatives, and the GP interviewed spoke very positively about the service provided.

The service has received a rating of continuous improvement for the focus on evidence based and best practice that has led to improvements for residents.

This audit has identified one area requiring improvement around Māori health.

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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

Policies are documented to support resident rights and residents stated that their rights are upheld. Systems protect their physical privacy and promote their independence. Individual care plans include reference to residents' values and beliefs.

Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained.

Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete these.

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.
---	--	--

Organisational performance is monitored through several processes to ensure it aligns with the identified values, scope, and strategic direction. The business plan is tailored to reflect the goals related to Jack Inglis Care Home. There are policies and procedures to provide appropriate support and care to residents with hospital, dementia, and rest home level needs. This includes

a documented quality and risk management programme with data analysed and improvements made as a result of discussion. Meetings are held at regular intervals to discuss quality and risk management and to ensure these are further embedded into practice. There is a health and safety management programme that is implemented with evidence that issues are addressed in a timely manner.

An orientation programme is in place and there is ongoing training provided as per the training plan developed for 2020 and 2021. Rosters and interviews indicated sufficient staff that are appropriately skilled, with flexibility of staffing around clients' needs. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. Registered nursing cover is provided twenty-four hours a day, seven days a week.

The 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.
--	--	--

The registered nurses are responsible for each stage of service provision. Residents' records reviewed, provided evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. These are then reviewed and discussed with the resident and/or family/whānau input. Care plans are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners (GPs), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. All staff responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

The diversional therapist implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and themed celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times. A contracted dietitian reviews the organisation's menu plans.

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.
--	--	--

Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

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.
---	--	--

Restraint minimisation and safe practice policies are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit there were no residents using restraint or enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours. The managers and staff have worked to identify individual strategies for residents other than using restraint or enablers.

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 control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (clinical manager) is responsible for coordinating education and training for staff. The infection control coordinator (ICC) has completed annual training provided internally and has access to external training provided by the local DHB. There is a suite of infection control policies and guidelines available to support practice. The ICC uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. There has been one outbreak in the previous year which was appropriately managed.

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	43	0	1	0	0	0
Criteria	1	91	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their families. Policy relating to the Code is implemented and managers and staff interviewed (the chief executive officer, clinical manager, two clinical nurse leaders, six caregivers, four registered nurses (RN), one enrolled nurse, one cook, activities coordinator, diversional therapist, one maintenance, one laundry staff, one cleaner) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents are included in the admission agreement and additional consents are signed by the resident or their enduring power of attorney (EPOA). The admission agreements have been signed on admission in the sample of files reviewed. Advanced directives sighted in the resident files were signed appropriately. The caregivers and managers confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on advocacy services is included in the resident information pack that is provided to new residents and their family on admission. Advocacy brochures are also available at reception. Interviews with residents and family confirmed their understanding of the availability of advocacy services.</p> <p>The complaints process is linked to advocacy services with this offered to any complainant if required.</p> <p>Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service with training records confirming this.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time and family interviewed confirmed that they can visit whenever they like. The main doors lock at dusk. Family are able to ring through to the RN if they wish to visit after hours.</p> <p>The service encourages the residents to maintain their relationships with their friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do as observed during the audit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>There is a complaints policy with responsibilities identified to ensure that all complaints (verbal or written) are fully documented and investigated. The chief executive officer and/or the clinical manager is responsible at this facility for addressing any complaints.</p> <p>A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/family members in various places around the facility. There is a complaints' register that includes relevant information regarding the complaint. There have been 12 complaints in 2020 and six in 2021 to date. Three were reviewed and all confirmed that complaints are responded to in a timely manner as per policy with each complainant confirming that they were happy with the outcome.</p> <p>Residents and family interviewed stated that they felt they could complain at any time and that their concerns had been dealt with in a timely manner to their satisfaction. They also stated that the managers were 'extremely competent and visible' which allowed for discussion and encouraged any concerns to be raised.</p> <p>One complaint was lodged with the Health and Disability Commissioner in 2019. This has now been closed out with no actions required. There have not been any other complaints from external providers</p>

		since then.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information folder that is provided to new residents and their families. A clinical nurse leader, clinical manager, or registered nurse (RN) discusses aspects of the Code with residents and their family on admission.</p> <p>Nine residents interviewed (four rest home including one using respite level of care, and five receiving hospital level care) confirmed that they received cares that met their needs, and all were aware of their rights. Thirteen family members interviewed (seven rest home including one using respite level of care, three with family requiring hospital level care, and three with family in the dementia unit) confirmed that staff had informed them of the Code. Discussions relating to the Code are also held during the resident and family meetings for those with family in the dementia unit.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' personal belongings are used to decorate their rooms. Rooms have ensuites and there are communal toilets as well. All have a mechanism or way of determining if the rooms are occupied to ensure privacy.</p> <p>The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed to occur during the audit. Caregivers reported that they promote the residents' independence by encouraging them to be as active as possible. All the residents and families interviewed confirmed that residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service. Incidents were reviewed for 2021 and there are no incidents around abuse. Staff and the general practitioner interviewed confirmed that there was no evidence of abuse or neglect.</p> <p>There are spiritual services and residents are encouraged to attend their own spiritual care in the community if they can. There is at least one church service a week. Any resident or family member can attend. Spiritual needs are individually identified as part of the assessment and care planning process.</p>
<p>Standard 1.1.4: Recognition Of</p>	PA Low	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported</p>

<p>Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>that they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident. There is one resident living at the facility who identifies as Māori and they were assessed for cultural needs as part of the interRAI assessment and care plan.</p> <p>Managers and staff have connections with local kaumātua and kuia who attend the site for staff and Māori resident support and blessing of site/rooms post death. There are close working relationships with Te Piki Oranga, the Māori health provider attached to Te Awhina Marae. A nurse manager from the marae is a trustee on the Board along with the chairperson of the Board. There are staff employed in the service who identify as Māori including the chief executive officer and others. Staff receive annual education on cultural awareness that begins during their induction to the service.</p> <p>There is a policy for recognition of Māori Values and Beliefs and a Māori Health Providers Policy. The Māori Hononga-Relationship Plan February 2019 - February 2022 includes an action plan that furthers equity for Māori including in areas related to facility expectations, consultation/sharing of information' to achieve Māori input, policy/procedures, Māori clients/residents, evidence of practice, and recruitment and retainment of Māori staff. Documentation of review of the plan was not able to be sighted.</p> <p>The service can also access support through the Māori Health Unit at the district health board if required.</p> <p>A family member who identified as Māori praised the staff for their cultural sensitivity and their ability to provide a holistic model of care as identified in policy (the whare tapa whā model). One resident interviewed also identified as Māori praised the service for support to reach out to their marae in the North Island and to engage in activities that met their needs. Care staff interviewed described the resident as 'lighting up' when they put on the Māori TV channel for them and when they included activities specifically related to their culture as part of the activities programme.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family, and/or their representative. Staff interviewed confirmed that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the care plan as sighted in the review of nine resident records (four rest home, two dementia, and three hospital). Residents and families interviewed confirmed they are involved in developing the resident's plan of care, which includes the identification of individual values and beliefs.</p> <p>There is one resident who identifies as Pacific and there is a staff member employed who is able to speak their language. Family also supports the resident.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There are implemented policies and procedures to protect clients from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries with residents.</p> <p>Residents interviewed stated that they have not experienced any discrimination, coercion, bullying, sexual harassment, or financial exploitation. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and managers stated that performance management would address any concerns if there was discrimination noted.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>The service meets the individualised needs of residents who have been assessed as requiring rest home, dementia, or hospital level care as identified through interviews with care staff and through an audit of resident files.</p> <p>The service has policies and procedures, equipment, and resources to support ongoing care of residents. The quality programme has been designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Meetings are conducted to allow for timely discussion of service delivery and quality of service including health and safety.</p> <p>Residents interviewed spoke very positively about the care and support provided. Both family and residents interviewed stated that the managers were very visible and encouraged open discussion at all times. Staff interviewed had a sound understanding of principles of aged care and stated that they are supported by the management team. Caregivers' complete competencies relevant to their practice.</p> <p>The general practitioner interviewed is satisfied with the care that is being provided by the service.</p> <p>The service has been awarded a rating of continuous improvement for continued improvements in service provision that have benefited staff, residents, family members and external service providers.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed, confirmed they were given an explanation about the services and procedures and were orientated to the facility as part of the entry process. They also stated their relatives are informed of changes in health status and incidents/accidents with family interviewed confirming that they were kept informed at all times. A review of 15 incident forms confirmed that family were informed in a timely manner when incidents occurred. Family interviewed also confirmed they were informed at all times.</p>

		<p>Resident and family meetings have occurred six-weekly. Residents and family confirmed that they find the meetings useful and provide opportunities to raise issues or concerns. Residents and family interviewed confirmed that the managers have an open-door policy and resolve concerns proactively.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available through the district health board with phone numbers identified in policy. There are staff on site who speak a range of languages. There are no residents currently requiring the use of interpreting services.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Jack Inglis Care Home is certified to provide rest home, dementia, and hospital levels of care in their care facility for up to 77 residents. On the day of the audit, there were 67 residents requiring care including 36 at rest home level including one under an ACC contract and three requiring respite level of care; 21 requiring hospital level of care; and 10 residents in the 10-bed dementia unit. All rest home and hospital beds are dual purpose. One resident requiring hospital level of care is under 65 years of age and under a young person with disabilities contract. All other residents unless already identified are under the Age-Related Care Contract.</p> <p>The CEO is responsible for the leadership and operational management of the service. The CEO reports to the Trust board four to six weekly. The CEO has been in the position for just over two years, is a registered nurse with post grad and business management qualifications. The chief executive officer has past experience in management including over 20 years working in health management/leadership at an executive level (service director and initial set up of an integrated health centre, manager of rural hospitals, and CEO roles in primary care and PHO management).</p> <p>The clinical manager has worked in aged care for over 13 years and has been in the role for two years. The clinical manager is supported by two clinical leaders. One has been in the role for five years and has a postgraduate diploma in nursing, specialising in gerontology. The second clinical nurse leader has been in the role for four years, has a postgraduate certificate in palliative care.</p> <p>All have attended at least eight hours of training relevant to their role.</p> <p>Strategic planning takes place with the board members and chief executive officer with input from others as required. An external consultant led the planning for the current business and strategic plan with this reviewed by the board at board meetings.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The CEO provides overall leadership and management of the service. The clinical manager relieves the chief executive officer if on leave. The clinical leaders and the CEO are responsible for the clinical functions of the facility if the clinical manager is on leave.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is an established organisation quality and risk management system. There are policies and procedures being implemented to provide assurance that the service 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 on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff. A document control process is well established.</p> <p>The annual residents/relatives survey for the service was last completed in September 2020 with 13 respondents. There is a high level of satisfaction and 86% stated that they would recommend the service to friends or family.</p> <p>There are schedules for training, meetings, and audit requirements for the year. The meeting schedule includes monthly staff and quality (including infection control) meetings. There are six weekly resident and family meetings and a daily hub meeting to touch base for staff and managers. Health and safety is a part of each meeting and the hub meetings. There is a monthly clinical meeting attended by the clinical manager, clinical nurse leaders and the RNs.</p> <p>The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans with evidence of resolution of issues as these are identified. Monthly and annual analysis of results is completed and provided to staff and to the board. There are monthly accident/incident reports that break down the data collected across the different levels of care. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed. Improvements are made as a result of analysis and discussion of data.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice. The service addresses health and safety by recording hazards and near misses, sharing of health and safety information and actively encourage staff input and feedback. The service ensures that all new staff and any contractors are inducted to the health and safety programme with a training completed by staff as part of orientation (staff records confirmed that these had been completed).</p>

		<p>Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Two of the four health and safety representatives were interviewed, and they could describe their role as per legislation and policy. Staff were able to give examples of where improvements had been made after issues had been raised.</p> <p>There have been a number of improvements in the service since the last audit. They include improvements in the organisational culture, improvement in the quality of care provided for residents, the development of an engaged and effective leadership team, role specific training and mentoring, a review of the 'House Rules' to a 'Code of Conduct' and elimination of the need for restraints and enablers.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Incident and accident data is being collected and analysed. A review of 26 incident/accident forms that occurred in 2021 identified they were all fully completed, including follow-up by a registered nurse (clinical manager or clinical nurse leader) and that family had been notified. Neurological observations were taken as per policy for 15 unwitnessed falls reviewed with a post-falls assessment completed for each. Near misses are also reported through the incident reporting system.</p> <p>The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes. Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been six section 31 notifications required since the last audit all in relation to pressure injuries.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Ten staff files (one CEO, clinical manager, two registered nurses, clinical nurse leader, two caregivers, cook, DT, maintenance staff) were reviewed and all had relevant documentation relating to employment.</p> <p>Performance appraisals have been completed annually. Copies of annual practising certificates are on file and a review confirmed that these were current, including RNs and external providers requiring these.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were orientated well to the service. The orientation programme includes a buddy system with the new staff member working alongside an experienced care staff member for five days. Care staff complete competencies as part of orientation relevant to their role. One new staff interviewed</p>

		<p>confirmed that they had a relevant and comprehensive orientation.</p> <p>There is an annual education plan in place. The 2020 and 2021 education plans have been implemented to date and staff stated that the training is relevant to their role. A competency programme is in place with different requirements according to work type (e.g., caregivers, RNs, and kitchen). Core competencies are completed, with a record of completion maintained. Staff interviewed were aware of the requirement to complete competency training. The service has 15 (including the clinical manager and clinical nurse leaders) with five interRAI trained. The clinical nurse leaders are also trained in interRAI.</p> <p>There are nine caregivers who work in the dementia unit. Eight who have completed level four dementia qualifications with one currently in training. There are six others with dementia training and an activities coordinator. Six caregivers have completed level three training and all others have completed level two training within their first year of employment.</p> <p>RN turnover has stabilised over the past year with staff turnover reported to and monitored by the board.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There are clear guidelines for increase in staffing depending on acuity of residents. A staff availability list ensures that staff sickness and vacant shifts are covered, and a review of rosters for the past three months confirms that staff are replaced when on leave.</p> <p>Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents. The chief executive officer and clinical manager both work 40 hours per week from Monday to Friday and are available on call for any emergency issues or clinical support. One clinical nurse leader provides clinical oversight and management of the dementia unit and is on duty 30 hours a week on day shift. The second clinical nurse leader is focused on the hospital residents and works 40 hours a week. The clinical nurse leader is replaced by a registered nurse on the days they are not there.</p> <p>In the dementia unit, there are two caregivers (long shift) on duty in the morning shift, two full shifts in the afternoon and one overnight.</p> <p>Three caregivers (all long shift) are designated as staff on the morning shift for hospital residents with three (long shift) on the afternoon and one overnight (15 hospital residents and 14 rest home residents). Three caregivers (all long shift) are designated as staff on the morning shift for rest home residents with three (long shift) on the afternoon and one overnight (6 hospital residents and 22 rest home residents).</p>

		<p>There is one registered nurse on duty on the morning and afternoon shifts for rest home residents and one registered nurse on duty on the morning and afternoon shifts for the hospital wing. There is one registered nurse over the facility on night shift. There are household assistants on seven days a week from 7.30 am to 2.30 pm who help with table setting and mealtimes.</p> <p>There are four caregivers in the casual pool, and they provide cover when staff are on leave.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24-hours of entry into each resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in a secure room. Archived records are secure in separate locked areas with password protection for all electronic records.</p> <p>Residents' files demonstrate service integration. Entries are legible, dated, timed, and signed by the relevant caregiver or nurse, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The clinical manager and clinical nurse leaders screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment, and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents, and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The nine admission agreements reviewed meet the requirements of the ARCC and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the clinical manager or clinical nurse leaders are available to answer any questions regarding the admission process.</p>
<p>Standard 1.3.10: Transition, Exit,</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and</p>

<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and documentation required for a resident transfer out of, and admission in to the facility.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-medicating on the day of audit, who had been assessed as competent to self-administer by the RN and GP. The resident's room was visited, and confirmation was obtained that the medications were stored securely. All legal requirements had been met. There are no standing orders in use and no vaccines stored on site.</p> <p>The facility uses an electronic medication management and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses, enrolled nurses and senior caregivers administer medications, have up to date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridges and room temperatures are checked daily. Eye drops viewed in the medication trolleys had been dated once opened.</p> <p>Staff sign for the administration of medications electronically. Eighteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The head cook oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring June 2021. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu is</p>

		<p>approved by an external dietitian.</p> <p>All resident/families interviewed are happy with the meals. Additional snacks are available at all times.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed. Initial interRAI assessments are evident for eight of nine resident files sampled (excluding respite resident) and six-monthly reviews had been carried out as per policy for those residents who had been in the service for six months or more.</p> <p>Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the dietitian, wound care specialist and older person's mental health team. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</p>
<p>Standard 1.3.6: Service</p>	FA	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner interviewed was complimentary of the service and care provided.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The kitchen staff were aware of resident's dietary requirements and these could be seen documented and were easily accessible for staff in the kitchen. Interventions are documented in order to guide the care staff. Care staff interviewed, stated that they found these very helpful.</p> <p>Wound assessment, wound management and ongoing evaluations are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included four chronic wounds, sixteen skin tears, two grade 3 pressure injuries (DHB acquired), three abrasions and seven classed as other (dermatitis, blisters).</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs, behaviour and wounds. All monitoring requirements including neurological observations had been documented as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is one diversional therapist, one activities coordinator and an activities assistant covering seven days who plan and lead all activities. Residents were observed participating in planned activities during the time of audit.</p> <p>There is a weekly programme in large print on noticeboards in all areas with the dementia unit having its own seven-day activity calendar. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, percussion sessions, crafts, games, quizzes, entertainers, pet therapy, bowls, and bingo.</p> <p>The service highlights any activities that may not be suitable for those residents under 65 years of age and provides alternatives, although a younger resident has the opportunity to attend any activity according to their preference.</p> <p>Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as hand massage are offered.</p> <p>There are twice weekly outings including a supported shopping trip. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated. There are visiting community groups such as cultural dance groups, churches, and children's groups.</p>

		<p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career, and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Residents interviewed were very positive about the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Seven of nine resident care plans reviewed (excluding the resident on respite and a relatively recent admission) had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. Written evaluations are completed. Activities plans are in place for each of the residents (including an individualised, age-appropriate plan for YPD resident) and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The clinical manager interviewed could describe the procedure for when a resident's condition changes and the resident needs to be reassessed for a higher or different level of care. Discussion with the clinical manager, clinical nurse leaders and registered nurses identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>The building holds a building warrant of fitness which expires September 2021. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>occurs.</p> <p>Electrical equipment has been tested and tagged, expiring August 2023. The hoist and scales are checked annually and are next due to be checked July 2022. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and decked areas are well maintained. All external areas have shade and seating and are easily accessible to residents. There is safe access to all communal areas.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Three resident rooms have no ensuite toilet and six share an ensuite. All other rooms have their own ensuite toilet and shower. There are also sufficient communal toilets and showers. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Privacy is assured with the use of ensuites. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings, and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All resident's rooms are single, and the service also has a family room adjoining a palliative care room for whānau wanting to stay. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are large and small communal areas including large lounges in the hospital, dementia, and rest home areas. Activities occur in all areas of the facility, with residents being assisted to activities in different areas if they require it. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The dining areas are spacious, inviting, and appropriate for the needs of the residents.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All laundry is done on site. There are clearly defined clean and dirty areas and entry/exit.</p> <p>There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times when in use and locked away at other times. All chemicals on the cleaner's trolley were labelled. Residents and family interviewed reported satisfaction with the cleaning and laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food, and supplies (torches, radio, and batteries), emergency power and barbeque. The facility keeps sufficient emergency water for 3 litres per person, per day for more than 3 days for resident use on site. The service has its own emergency generator in case of power outage.</p> <p>There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed. A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction and is ongoing. All shifts have a current first aider on duty.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on a display panel and also give an audible alert. Security policies and procedures are documented and implemented by staff. The buildings are secure at night and there is security lighting externally. A local security company checks external doors as part of a night patrol.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled with staff and residents interviewed, stating that heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p>	<p>FA</p>	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control coordinator (clinical manager) is an RN who is responsible for infection</p>

<p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>control across the facility as detailed in the infection control coordinator job description (signed copy sighted on day of audit). The coordinator oversees infection control for the facility, reviews incidents on the electronic resident management system and is responsible for the collation of monthly infection events and reports. The facility management team are responsible for the development of, and annual review of the infection control programme.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Covid sign in and declarations are mandatory for visitors and contractors. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. There has been one scabies outbreak since the last audit which was appropriately managed.</p> <p>Covid-19 education has been provided for all staff, including hand hygiene, donning/doffing and use of PPE.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Jack Inglis Friendship Hospital. The infection control coordinator liaises with the quality/infection control committee who meet regularly and as required (more frequently during Covid lockdown). Information is shared as part of staff meetings and also as part of the registered nurse meetings. The infection control coordinator has completed annual training in infection control through the local DHB.</p> <p>External resources and support are available through external specialists, microbiologist, GP, wound nurse and DHB when required. The GP and pharmacist monitor the use of antibiotics. Overall effectiveness of the programme is monitored by the facility management team.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by the clinical manager, building upon a bought in system to make them site specific.</p>

service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating education and ensuring staff attend education in-services. Training on infection control is included in the orientation programme. Staff have completed infection control education including Covid specific topics in the last 12 months. The infection control coordinator has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is an integral part of the infection control programme and the purpose and methodology are described in the Jack Inglis Friendship Hospital surveillance policy. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified, and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the registered nurse, staff, and infection control meetings. Meeting minutes are available to staff.</p> <p>Infections are entered into the electronic database to facilitate trend analysis. Corrective actions are established where trends are identified.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The use of restraint is a clinical decision made by the registered nurse or manager in partnership with the GP. The GP completes the verification section on the specific consent form and also records a note in the medical continuation notes outlining the rationale for verifying or not verifying the use of restraint. The family will be involved in as many aspects of the decision as possible, and their input recorded on the assessment form and in the progress notes by the RN. There were no residents using restraint or enablers on the day of audit.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.	PA Low	The service has extensive links into the community including to the local Māori provider. Māori family and residents interviewed stated that the service is culturally sensitive to their needs and this is documented in plans reviewed. The Māori Hononga-Relationship Plan February 2019 - February 2022 is documented with board minutes confirming that the plan was presented to the board. Some review of the plan has occurred in 2019 as sighted in meeting minutes reviewed.	The Māori Hononga-Relationship Plan February 2019 - February 2022 is documented, but to date there is no evidence of evaluation of progress against the plan	Ensure evaluation of progress to meeting the Māori Hononga-Relationship Plan is documented. 180 days

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has reviewed and upgraded equipment and infrastructure to improve services for residents, staff safety, injury prevention and improved ability for staff to spend quality time with residents. Key improvements are as follows. i) The service has provided evidence-based clinical care for a bariatric resident that has resulted in increased resident and staff safety, a reduction in pressure injuries and wounds, and improved quality of life. ii) An electronic patient information system has been introduced that has decreased time taken by staff to document care and improved continuity of care and the service has changed</p>	<p>There are a number of improvements that have focused on providing evidence-based and best practice for residents in the service. Examples of these are as follows.</p> <p>An electronic patient information system has been introduced and is now well used by all staff. Care staff stated that there is more time to spend with residents and that information is integrated and user friendly. The service has put in tablets throughout the facility that allow staff to document in real time.</p> <p>The service is now restraint free following a review of equipment and practice. A plan has been implemented to initially reduce numbers of residents using restraint or enablers with lo beds purchased, an increase in sensor mats, through assessments around falls and behaviour and buy-in from family to the discussion process. Staff can describe using interventions now when in the past they would have used restraint.</p> <p>The service has moved from one electronic medication system to another to</p>

		<p>electronic medication systems to accommodate external providers. iii) The service is now restraint free following a review of equipment and practice.</p>	<p>accommodate external providers and to promote service integration with the multidisciplinary team. This has improved links with primary care team and specialists at the district health board. This has facilitated a uniform approach to medication management and reconciliation with offsite providers being able to see and make changes in real time.</p> <p>Examples of individualising care to specific needs of the resident were sighted. The service demonstrated that they respond to needs and often 'go the extra mile' to provide safe and appropriate care. One resident felt unsafe and uncomfortable with equipment that was often broken and that caused injury. They also had a poor quality of life. The service has provided specialised equipment that included upgrading the hoist to accommodate the resident, provided custom made slings, and a customised bed. They have strengthened the ceiling to take the weight of the hoist. The mobility device has been reassessed and the external provider brought in to adjust settings that have improved safety for the resident and others. Outcomes for this resident have been monitored with no pressure injuries or hospital admissions since the review and upgrade of equipment. The resident and family praised the service for care and for going the extra mile to support them as a family with other family and residents interviewed confirming that their experiences were similar. Care staff interviewed could describe cares as per the care plan for each resident and residents stated that they were encouraged to maintain their independence and community links with support from the activities team and external providers. Family and residents also stated that they received care without prejudice or discrimination and were given the respect and dignity afforded to all clients.</p>
--	--	--	---

End of the report.