

# FOMHT Health Services Limited - Jack Inglis Friendship Hospital

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## Introduction

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

The audit has been conducted by 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:** 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: 18 December 2018 End date: 19 December 2018

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit: 67**

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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.

Currently there is an interim manager /quality assurance manager who is supported by a support manager and clinical manager.

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

The service has addressed seventeen of the nineteen previous shortfalls relating to: complaints management and complaints register; personal belongings; resident respect; good practice; corrective actions; open disclosure, adverse event documentation; staffing; service delivery timeframes; assessments; wound management; evaluations; short-term care plans; activity programme, infection control (IC) programme and (IC) policies. There continues to be improvements required around care plan interventions and medication management.

This surveillance audit identified a further three shortfalls regarding contractor management and hazard register, training records and competencies and self-medication.

## Consumer rights

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

The complaints policy and procedures are in line with the Health & Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code) and includes timeframes for responding to a complaint. Complaints are being managed in accordance with guidelines set 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.		Some standards applicable to this service partially attained and of low risk.
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There have been substantial improvements in implementation of the quality management system since the previous audit. Policies and procedures were up to date and referenced to current legislation and the best practice. The internal audit system is fully implemented and includes corrective action plans where required, and sign-off. Benchmarking data is reviewed, and improvements have been identified and implemented as a result of this review.

Individual adverse/incident/unplanned event forms are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident data links to the organisation's quality and risk management programme. All incident data is reviewed, and data discussed at the several meetings including quality and staff meetings.

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice.

The service uses electronic staffing roster. Sufficient staff are rostered on to manage the care requirements of the residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident (as appropriate) and/or family/whānau input. Care plans reviewed in resident records demonstrated service integration and six-monthly evaluations. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers responsible for administration of medicines complete education and medication competencies.

The activity team facilitate the activity programme in each unit for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site by a qualified chef. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Nutritional snacks are 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.
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There is a current building warrant of fitness.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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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 with a restraint and one resident using an enabler. Staff training has been provided around restraint minimisation and management of challenging behaviours

## 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 coordinator (clinical manager) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. These included audits of the facility, hand hygiene and surveillance of infection control events and infections.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	18	0	2	2	0	0
Criteria	0	48	0	2	3	0	0

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints policy and procedures are in line with the Health &amp; Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code) and includes timeframes for responding to a complaint. The complaint forms are available at the entrance to the facility. A complaints register is in place and includes 27 complaints since July 2018. Communication with the complainant was maintained in the folder and outcomes of the complaints discussed in the meetings.</p> <p>The complaints register reviewed indicated that verbal and written complaints are captured. Nine complaints were reviewed at this audit, and documentation, including follow-up letters and resolution, demonstrated that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p> <p>Complaints have been managed by the interim support manager. The service completed a post palliative care family survey. Each result was individually evaluated, and any concerns were addressed as part of the complaint management process, and corrective actions were developed and implemented. Residents and family members could describe their rights and advocacy services particularly in relation to the complaints process. Feedback is provided to staff on the complaints through meetings and the Board is also informed through monthly reports.</p> <p>Residents and family interviews confirmed that they were aware of the complaints process and they stated they had not lodged any new complaints since the previous audit.</p>

		Staff interview confirmed that they understand the complaints process for written and verbal complaints when they occur and confirmed the training and awareness around complaint management. The previous partial attainments around complaint management and complaints register has been addressed.
<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 previous audit identified issues around risks of abuse and neglect, and professional boundaries. Several training sessions were provided to address these issues. Initially a request was sent to an external Aged Care Consultant to provide training to staff around professional boundaries and the complaints process, and that all staff were expected to attend. However, this training did not go ahead as planned due to unavailability of the external consultant. As an alternative, training was provided by the staff development nurse, the management team and external trainers. Behaviour of concern training was provided by another external provider in September 2018. Staff files reviewed included information about professional boundaries at work. Residents rights training was provided over two days (forty-four staff participated).</p> <p>Lack of care to personal belongings was another issue identified at the previous audit. Inspection of the laundry confirmed that residents' clothing was labelled and appropriately placed. Laundry staff stated that since the previous audit, they have given extra care to residents' personal belongings. Meeting minutes included discussion and staff communication regarding laundry services and residents' personal items. Residents and relative interviewed were satisfied with the laundry service and no issues were raised.</p> <p>Staff interviews (six caregivers, two RNs, a diversional therapist, two cleaners, and a laundry staff) stated that they attended all above training and including tool box discussions around behaviour management. Training records evidenced of several policies being read and signed off. All care plans documented the requirement for resident privacy and respect.</p> <p>Complaints have been taken seriously, and several investigations have been completed since the previous audit. One investigation was undertaken by the support manager following an allegation by a staff member regarding abuse and neglect. Investigation results showed no evidence of abuse or neglect, but professional boundaries were identified as a concern. Consequently, a training was provided to address this issue. In addition to this, a review was completed by an external consultant with many years of experience in aged care. This review showed no evidence of concern related to abuse or neglect since the change of management.</p> <p>One family member interviewed stated that she was interviewed in the previous audit in May, and now she feels that her concerns were addressed. The family member reported positive changes in culture of the organisation. The other three families interviewed did not raise any issues and stated that their loved ones were being treated with dignity and respect.</p> <p>Staff interviewed expressed confidence in the recent management team. They understand consumer rights and their responsibilities around professional boundaries. Since the previous audit, there have been</p>

		marked improvements in change of organisational culture therefore both auditors confirmed that required corrective actions related to this criterion have been addressed.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The quality assurance programme is implemented and monitors contractual and standards compliance and the quality of service delivery. Since the previous audit, the service completed a review on their policies and procedures which are current and make reference to relevant legislation and best practice. Therefore, the service has addressed the previous finding. A number of improvements have been made since the previous audit around clinical care, human resource management and consumer rights. Communication has improved between residents, families and staff. Post palliative care and residents lifestyle surveys were completed in order to obtain consumer feedback. These results were reviewed, corrective action plans were developed and implemented.</p> <p>Resident, family and staff meetings occur regularly, and meeting minutes reflect open disclosure and management effort to change organisational culture. Residents and family meetings occur as planned and meeting minutes were maintained. Staff survey is completed, and results were reviewed, and corrective actions were put in place.</p> <p>Clinical data reviewed monthly and priority was given to falls prevention. Resident's call bells are being monitored, and a corrective action plan was put in place to address identified issues. Incident and accident data is collected, analysed and corrective actions are being implemented. This data has been communicated to staff through meetings, memos and during handovers.</p> <p>Training activities has increased, and the service aims to have 100% training attendance in subjects related to the consumer rights.</p> <p>The Board report template has been edited and a more detailed report regarding quality activities, and health and safety was evident in two Board reports reviewed.</p> <p>Document review and interviews with staff, management (interim manager/quality assurance, support manager, clinical manager and clinical nurse leader), residents (two rest home and one hospital) and families (two dementia and two hospital) provided strong evidence that the service has improved their practices around consumer rights, human resource management and clinical care.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>The policies and procedures concerning complaints, open disclosure and accidents/incidents alert staff to their responsibility to notify family/enduring power of attorney (EPOA) of any accident/incident that occurs. These procedures guide staff on the process to ensure that full and frank open disclosure is available. Accident/incident forms evidenced family are informed if the resident has an incident/accident.</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>Family contact is recorded in residents' files, and interviews with residents and families confirmed that they are kept informed regarding the changes in delivery of care.</p> <p>Review of the complaint management process showed that complaints have been reviewed, and documentation, including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p> <p>Since the previous audit, a post palliative care survey was completed, and the outcome of this survey has been communicated to the respondents and staff. A resident's lifestyle survey results were reviewed, and corrective action plans were developed and implemented. A number of corrective actions took place following these surveys. Communication has improved, and the support manager and interim manager/quality assurance have implemented an open-door policy. Family and staff interviews confirmed this.</p> <p>Resident and family meetings occur bi-monthly and meeting minutes evidenced open communication.</p> <p>Memos were sighted in the quality assurance folder and in the staffroom regarding training, professional boundaries and open disclosure. Staff communication also occurred through meetings and the electronic staff roster. Improvements have been made to change blame culture to open communication. In light of this evidence, the auditors considered that the partial attainment from the previous audit is now closed.</p> <p>Interpreter services are available from the district health board. Staff demonstrated an understanding of how to access interpreter services when required. There are no residents requiring interpreting services. The information pack is available in large print and this could be read to residents.</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 Friendship Hospital provides dementia, rest home and hospital level of care for 77 residents with 72 dual service beds (hospital and rest home). There are ten beds in the secure dementia unit.</p> <p>This audit also included verifying the reconfiguration of bed numbers since previous audit. The dementia unit beds have dropped from 15 beds to 10 beds. Five beds have been added into the dual service bed capacity by moving of a secure door. Total bed capacity remain unchanged.</p> <p>Occupancy on the first day of audit was 67 residents, including 14 residents receiving hospital level care (including two residents under the young persons with disability contract), 43 residents receiving rest home level of care (including one resident under an Accident Compensation Corporation contract, three residents under a primary care contract and one resident under respite care) and 10 residents in the secure unit. The service also has a day care contract.</p> <p>The service has a documented vision, mission statement, philosophy and values. The Trust Board is responsible for governing the facility and the Board meets monthly. The Trust Board is in the process of appointing a new general manager who was expected to start in early 2019. Since the certification audit,</p>

		<p>the previous general manager resigned from her role and the Board temporarily appointed a support manager who is an experienced manager /RN with aged care background. The quality assurance manager has undertaken the interim manager role. The managers are supported by the clinical manager, the clinical leader and the training manager.</p> <p>The interim manager/quality assurance manager is an RN with previous experience as a district nurse working with palliative care and Tui Ora Maori Health. The clinical manager has previous RN experience and has been in the role since May 2018. She has undertaken a post grad diploma in gerontology.</p> <p>The management team have completed at least eight hours of training relevant to managing a hospital.</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>	PA Low	<p>There have been substantial improvements in implementation of the quality management system since the previous audit. Policies and procedures are up to date and referenced to current legislation and best practice.</p> <p>Internal audit system is implemented. Following completion of internal audits, corrective action plans have been documented, and resolution of issues were completed. There is collection, collation, and identification of trends through analysis of data. The previous finding around corrective actions has been addressed. Benchmarking data is also reviewed, and improvements were identified and implemented as a result of this review.</p> <p>Clinical meetings occur weekly and individual residents are reviewed in this meeting. Hub meetings occur daily, and all staff are invited to this meeting. This ensures communication between different wings.</p> <p>A fall coordinator role and fall prevention champions have been established. Staff have completed a number of trainings around falls prevention. Falls data is being analysed and corrective actions have been implemented where required. Falls data is being reviewed on a case-by-case individual level and referrals to physiotherapist has occurred where required, and care plans updated as a result. The 'nature of falls' and 'falls with injury' are also reviewed separately along with wing call bell response time.</p> <p>Infection Control (IC) data is being analysed and reviewed monthly. This is discussed in the quality improvement/ management and staff meetings. Complaints are a standing agenda in the quality improvement/ management meetings and staff meetings. Quality review of restraint minimisation occurs.</p> <p>The health and safety programme was reviewed in October 2018, and 2019 objectives developed. There is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk, however, the risk matrix was not included. A health and safety manual is available that includes relevant policies and procedures. Implementation of the health and safety programme is a work in progress, but contractors have not received an induction.</p>

		<p>The service completed two surveys since the previous audit including post palliative care survey and resident's lifestyle survey. Both results were reviewed, and corrective actions were identified and implemented.</p> <p>Staff survey was completed which shows increased staff morale. A number of training and initiatives were put in place to support staff to create a positive work environment. Examples include: a) staffing numbers have been increased; b) communication has improved through memos, daily hub meetings, messages to staff through electronic pay roll system; and c) roster adjusted to enable staff to take weekend breaks. Positive engagements have been noted in the staff meeting minutes. Staff interviewed were reporting positive progress towards healthy work place culture.</p> <p>The management reported that several staff members have returned to the organisation since the previous audit and consequently staff morale has improved.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>Individual adverse/incident/unplanned event forms have been completed for each incident/accident, with immediate action noted and any follow-up action(s) required.</p> <p>A sample of 10 incident forms were reviewed (July to December). All forms were fully completed and signed off by the management. Each event involving a resident had a clinical assessment and follow up by an RN. Neuro observations were completed following unwitnessed falls with suspected head injury. Falls data has been separately analysed and corrective actions developed and implemented. Pressure injuries are being reported through adverse/incident/unplanned event reporting. This data is linked to the organisation's quality and risk management programme and benchmarked against similar facilities in NZ. All events have been reviewed, and data was discussed at the several meetings including quality and staff meetings. The previous finding has been addressed.</p> <p>Staff confirmed during interviews that they are made aware of their responsibilities for completion of adverse events and they are encouraged to do so. They also confirmed that this data is reviewed and discussed at the staff meetings.</p> <p>Interviews with the quality assurance /interim manager confirmed awareness of their requirement to notify relevant authorities in relation to essential notifications. Reduction of the dementia bed numbers was notified to HealthCERT Team. A section 31 notification was completed around change of clinical manager and Public Health Authorities were notified of the norovirus outbreak in September 2018.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p>	PA Low	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Ten staff files were reviewed (the clinical manager, five caregivers, three RNs and a cook). All staff files evidenced implementation of the recruitment process, employment contracts, completed</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>orientation, job descriptions, confidentiality statement, and competencies. Performance appraisals were completed three months after employment and yearly thereafter. This was evidenced in all files reviewed. The service employs eight RNs and two enrolled nurses. A register of practising certificates is maintained. There are four interRAI trained RNs including the clinical nurse leader.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>The training programme is implemented but a training register is not maintained. There is a competency assessment schedule which shows yearly and two-yearly competencies, however, male catheterisation was not included in the competency schedule.</p> <p>There are seven caregivers who works in the dementia wing. Six caregivers have completed the required dementia standards and one started her employment six months prior to this audit. The facility employs a diversional therapist who has completed the dementia standards.</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>The service uses electronic staffing roster. Sufficient staff are rostered on to manage the care requirements of the residents. Staffing hours have been increased since the previous audit and roster shows that staff shortages were covered. At least one RN is on site at any one time. In addition to this, three RNs were rostered for paper work on weekly basis. There is a newly appointed senior nurse position to provide support to the clinical manager and she works 40 hours a week. Dementia unit has 10 bed capacity and the roster shows two caregivers in the morning and afternoon duties and one caregiver at night. There are three days clinical nurse/RN cover a week.</p> <p>Gardenia wing has 29 beds and on the day of audit, there were 24 rest home and three hospital level care residents. The roster showed four caregivers in the morning (two x five-hour shift and two x eight-hour shift), two in the afternoon (one x eight hours and one x seven hours shift).</p> <p>Magnolia and Camelia wings have 38 beds (including three primary care beds which were unoccupied during audit) and on the day of audit, there were 19 rest home and 11 hospital level care residents. The roster demonstrated five caregivers in the morning (three x eight hour shifts and one x five hours and one x seven-hour shift) and four caregivers in the afternoon (two x eight-hour shift, one x five hours and one x six hours. There are three caregivers rostered at night and one remains in the dementia unit.</p> <p>Clinical Manager works full time, Monday to Friday and based in the Magnolia and Camelia wing and provides oversight to whole facility. Clinical Nurse leader works in the dementia wing, three days a week.</p> <p>Staffing number was increased from 76 to 84 since the previous audit. The service advertised to cover staff leaves and set up a casual staff pool. Staff interviews confirmed that some of the previous staff returned to work and the management employed new staff to cover gaps in the roster. Review of the employment</p>

		records included completed orientation and police checks. Staff interviews confirmed that new staff were appropriately orientated to the service and they were supported. Staff, resident and family interview did not raise any concerns around staffing levels. Therefore, previous partial attainments are now closed.
<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>	PA Moderate	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. However, practice around administration of controlled medications was not compliant as observed on the day of audit. Clinical staff who administer medications (RNs, enrolled nurses and senior caregivers) have been assessed for competency on an annual basis. Education around safe medication administration has been provided. The RN checks incoming medication blister packs against the electronic medication chart and signs a paper-based verification form when the packed have been checked. Medication is stored safely in the locked medication room of each unit. Medications is stored safely in each of the three units. Expiry dates are checked by the RN. All medications were within the expiry dates. Eyedrops had been dated on opening. Medication fridge temperatures are monitored and recorded daily with corrective actions recorded for temperatures outside of the acceptable range.</p> <p>There were two rest home residents self-medicating. Not all requirements for self-medicating residents had been implemented.</p> <p>All 12 medication charts reviewed (including the respite resident) on the electronic medication system met legislative prescribing requirements. The GP had reviewed the medication charts three-monthly. All medications had been administered as prescribed. There were photographs, and allergy status identified on the medication charts. The previous finding around medication charts has been addressed.</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>	FA	<p>A chef manager has been employed since July 2018 to oversee the food service at the facility. The service also provides meals on wheels to the community. The food control plan has been verified and expires 31 October 2019. The four-week menu has been reviewed by a dietitian. The chef and kitchenhand serve meals to the rest home and hospital residents from bain maires in the dining rooms. Meals are delivered to the dementia care unit in a hot box and served by care staff. The chef manager receives dietary profiles for each resident and is notified of any dietary changes. Dislikes are known, and alternative foods provided. Pureed meals are provided. Nutritional snacks are available 24 hours in the dementia unit.</p> <p>A daily checklist is completed which includes fridges, freezer and chiller temperatures, end cooked food and cooling temperatures and chilled/frozen on delivery. All perishable goods were dated as were the dry goods in the pantry. The chemical provider completes a monthly function check on the dishwasher. A cleaning roster is maintained for cooks and kitchenhands. All staff have completed training in food safety and hygiene.</p>



		Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.
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 applicable risk assessment tools such as falls, pressure injury, continence, pain, nutritional assessments and behaviour assessments. An interRAI assessment is undertaken within 21 days of admission, six-monthly, or earlier due to significant changes in health for long-term residents including the resident under 65 years of age. Resident needs and supports identified through the assessment process form the basis of the initial support plan and long-term care plan. InterRAI assessments, assessment notes and summary were in place for all resident files sampled. Outcomes of behaviour assessments completed for the two dementia care residents were reflected in the 24-hour behaviour management plan. The previous finding around incomplete assessments has been addressed.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Resident care plans reviewed were resident focused and individualised. All identified support needs as assessed were included in the care plans for all resident files reviewed, however, not all interventions were documented in care plans for three residents. The previous finding around documented interventions remains. The outcomes of interRAI assessments link with the long-term care plans. Behaviour management (action) plans were in place for the two dementia care files with de-escalation strategies including a 24-hour activity plan that identifies the resident's pattern of behaviour over 24 hours.  Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were notified of an upcoming multidisciplinary (MDT) review and were involved in the care planning process. Resident files demonstrate service integration.  There was evidence of allied health care professionals involved in the care of the resident including the GP, physiotherapist, speech language therapist, dietitian, geriatrician and mental health services.
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 alters, the registered nurse initiates a review and if required, GP, dietitian or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the resident family/whānau communication record held in the resident file.  Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures

		<p>are in place. Wound assessments, treatment and evaluations were in place for 13 residents with wounds (skin tears, abrasions and 2 chronic wounds). There were six facility acquired pressure injuries on the day of audit (one stage one, two stage two and three suspected deep tissue injuries. Change of dressings were completed as per the documented dates and photos demonstrated the healing progress. There were adequate pressure injury prevention resources sighted available and in use. The district nurse wound nurse specialist has been involved in the management of pressure injuries and chronic wounds. The hospice nurse provides input for palliative care residents with pressure injuries. Care plans guided staff in the pressure injury prevention strategies including re-positioning of residents in chairs and the bed, use of air alternating mattress, redistributing cushions, heel protectors, monitoring and reporting any skin integrity problems. The district nurse wound nurse specialist has been involved in the management of pressure injuries and chronic wounds. The previous finding around wound management has been addressed.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>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, pain, re-positioning, food and fluid intake, and challenging behaviour.</p> <p>Short-term care plans document appropriate interventions to manage short term changes in health.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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>	FA	<p>The service has a full-time qualified diversional therapist (DT) who oversees the activity team and coordinates the seven-day integrated rest home/hospital programme and the dementia unit activities. A part-time DT assists with activities in the rest home/hospital and an activity coordinator works four days a week in the dementia unit, supported by caregivers who incorporate activities into their role. There are a number of volunteers involved in activities. The activity programme is displayed in resident rooms and noticeboards throughout the facility. Care staff assist residents to attend activities of their choice within their unit or to a combined activity.</p> <p>The programme is planned to reflect the cognitive and physical abilities of the groups of residents. Activities offered include (but not limited to): a variety of exercises (chair, sit and be fit, stretch); newspaper reading; board games; quizzes; bowls; reminiscing; music; happy hours; movies; and ice-creams. One-on-one time is spent with residents who are unable to or choose not to join in group activities. There are integrated activities such as entertainment, movies, church services, guest speakers offered for all residents including dementia care residents (as appropriate) under supervision. Other community visitors include school children, volunteers and canine pet therapy.</p> <p>Activities in the dementia care unit are flexible and meaningful for the individual resident and include</p>

		<p>reminiscing, sing-a-longs, baking, bird feeding, gardening, walks and domestic activities. Each resident has a 24-hour activity plan that is personalised with the resident's daily activities, potential behaviours and de-escalation strategies including activities. The DT is involved in the six-monthly evaluation of the 24-hour activity plan, behavioural management plan and care plans with the MDT. The previous finding around 24-hour activity plan and behavioural management plans has been addressed. The DT, clinical nurse leader and care staff interviewed could describe individual resident behaviours and strategies for de-escalating behaviours. There were no behaviours of concern observed on the day of audit. The previous finding around behaviours of concern has been addressed.</p> <p>A resident profile is completed within three weeks of admission and an activity plan completed on admission, in consultation with the resident/family (as appropriate). Activity plans in all files were evaluated six-monthly.</p> <p>There is an opportunity for residents and families to provide feedback and suggestions for the programme through resident meetings, relative meetings, surveys and one-on-one feedback. Residents and relatives interviewed on the day of audit commented positively on 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>All initial care plans reviewed in long-term resident files had been evaluated by the RN within three weeks of admission. Long-term care plans had been evaluated following the routine interRAI assessments and changes made to reflect the level of support required to meet the resident goals. The previous finding around care plan evaluations has been addressed. Short-term care plans sighted for short-term problems had been evaluated regularly and included sufficient detail to guide staff in delivery of care. The relatives (as appropriate) and/or resident is involved in the MDT reviews. There is documented evidence of families being invited to attend the MDT and care plans are signed at the review. The GP reviews the residents at least three-monthly or earlier if required. The MDT review includes feedback from the RN, caregiver, DT, pharmacist, GP, physio, podiatrist, dietitian as applicable and the resident/relative. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and are evident in changes made to care plans (link 1.3.5.2).</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their</p>	FA	<p>The building has a current warrant of fitness that expires 29 September 2019. There is a reactive and planned maintenance programme in place.</p>

purpose.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The clinical manager was appointed May 2018 and has responsibility for infection control across the service. She is supported by an Infection Control Committee who meet two-monthly to review infection control practice, collation of events, training and resources. An annual review of the infection control programme was sighted for 2017 and 2018. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the influenza vaccine.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The policies have been developed by an aged care consultant and 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 reviewed to reflect the services provided at the facility. The previous finding around policies and procedures has been addressed.</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>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is discussed at the Infection Control Committee meetings, clinical and staff meetings. Minutes are made available to staff. The service completes monthly and annual comparisons of infection rates for types of infections. An antibiotic register is maintained. The GPs monitor the use of antibiotics. Trends are identified, analysed and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There has been one outbreak in September 2018 of confirmed norovirus. Case logs and appropriate</p>

		documentation including notification to the relevant authorities.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers that align with the standard definitions. The clinical manager is the restraint coordinator. There were no residents using restraints and one rest home resident voluntarily using an enabler lap belt on the day of audit.</p> <p>Staff receive training around restraint minimisation and managing challenging behaviours. Restraint competencies have been completed. Care staff interviewed were able to describe the difference between an enabler and a restraint.</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)
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Low	<p>The health and safety programme was reviewed in October 2018, and 2019 objectives developed. There is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. However, the risk matrix has not been included. A health and safety manual is available that includes relevant policies and procedures. Implementation of the health and safety programme is a work in progress and contractors have not had induction.</p>	<p>(i)Hazard register does not include risk matrix; and (ii) Not all contractors have completed a health and safety induction to the facility.</p>	<p>(i)Ensure that the hazard register is updated to include a risk matrix. (ii) Ensure that a health and safety induction of contractors occurs, and this is documented.</p> <p>90 days</p>

Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	<p>The organisation has a nurse educator role composing of 0.4 full time equivalent (FTE) who works with the quality assurance manager and is responsible for the in-service education programme. There is a 2018 training programme in place that is being implemented. Since the previous audit, staff have received more frequent training around consumer rights and the service aims to have 100% training records on this topic and dementia training. However, review of the training records showed that although increased number of training has been facilitated, attendance records have not been maintained in the staff training register to identify staff training gaps.</p> <p>Electronic training records did not match with paper-based training records. There are a number of identified compulsory sessions, but records did not identify staff who have not attended. RNs are supported to maintain their professional competency. Registered nurses have completed syringe driver, fundamentals of palliative care, diabetes, pressure injury, professional boundaries and first aid training.</p> <p>There is a competency assessment schedule which shows yearly and two-yearly competencies. Male catheterisation has not been included in this schedule, although there were residents requiring male catheterisation.</p>	<p>(i) Staff training records have not been maintained in the register to identify staff training gaps. (ii) Competency assessment for male catheterisation is not in place.</p>	<p>(i) Ensure staff training register is maintained to fully identify gaps. (ii) Ensure that RNs who male catheterisation are assessed as competent to do so</p> <p>90 days</p>
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<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>The one controlled medication safe is in the hospital unit. All controlled medications are named and within the expiry dates. There are weekly controlled medication checks and six-monthly audits, last in December 2018. The register evidenced the checking out of medications by an RN and a second medication competent RN or caregiver. A controlled medication checked out was sighted to be incorrectly stored awaiting administration.</p>	<p>(i)A check on the medication trolley in the hospital unit revealed an unlabelled syringe that was confirmed to be a controlled medication in the form of an elixir. The controlled drug register checking out procedure was correct; however, the medication was not administered after being checked out and was not stored safely in the medication trolley (unlabelled). The risk was reduced from high to moderate as the appropriate action was taken immediately to reduce the risk.</p>	<p>Ensure compliance of the medication policy for the administration of controlled medications is adhered to.</p> <p>30 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Moderate</p>	<p>There were two rest home residents self-medicating. Both had current competencies signed by the RN and GP which were reviewed three-monthly. Not all requirements for self-medication had been met.</p>	<p>Two of two rest home resident's self-medicating did not have the following in place: (i) medications/inhalers that were self-medicated were not identified on the medication chart; (ii) there was no weekly monitoring in place and; (iii) the resident medication drawers were not locked on the day of audit.</p>	<p>Ensure self-medication practices align with the policy.</p> <p>30 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes</p>	<p>PA Moderate</p>	<p>The long-term care plan for three of six residents (two hospital and one dementia care) described all the required interventions to meet the resident/relative goals. However, not all interventions were described in the</p>	<p>(i)There was no pain management plan for one respite care resident with identified pain, (ii) there were no documented interventions for</p>	<p>Ensure interventions are documented to meet the</p>



identified by the ongoing assessment process.		respite support plan and two long-term care plans (one rest home and one dementia care)	one rest home resident with recurring nose bleeds as per GP notes, and (iii) the care plan for one dementia care resident did not identify a history of weight loss or interventions to manage weight loss.	resident/relative goals.  90 days
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## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.