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 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: 20 May 2019 End date: 21 May 2019

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 62

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 for up to 77 residents. On the day of the audit there were 62 residents.

The certification audit was conducted against the 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 a GP.

The service has a documented vision, mission statement, philosophy and values. The Trust Board appointed a new CEO in early 2019. The CEO has over 20 years working in health management and leadership. She is a RN and with a current practicing certificate. She is supported by the quality assurance manager and the clinical manager.

This audit identified shortfalls around management of health and safety, human resource management, staff training, care planning and two aspects of restraint minimisation.

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.

The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. Training around professional boundaries and Vulnerable Person Act are provided to staff in March – April 2019. The service ensures that all staff completes these training activities. Residents and families interviewed spoke positively about the care and support provided. There is a Māori health plan to support practice and individual values are considered during care planning. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

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 medium or high risk and/or unattained and of low risk.

The service has a quality and risk management plan which is designed to monitor contractual and standards compliance. Policies and procedures are up to date and reviewed by the management team, and external advice is obtained as required. A resident and family/whānau survey was completed in March 2019 and survey results were communicated to staff, residents and families.

Satisfaction survey results were positive and individual comments related to improvements to the service have been listed and consequently, several improvements have been made. An internal audit programme is implemented. The health and safety role is reassigned to the clinical nurse leader who has relevant training to undertake this role. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to various meetings.

Staff files reviewed contained documentation relating to evidence reference checking, completion of an orientation programme and job descriptions. Annual appraisals were completed for all staff who had been employed for more than twelve months. Current annual practicing certificates are kept on file.

There is a comprehensive training plan in place and in the last 12 months, a priority was given for increased training around consumer rights, professional boundaries, communication and the aging process. A high number of training participation and repetitive training sessions were noted in the training records.

The service uses an electronic staffing roster. Sufficient staff are rostered on to manage the care requirements of the residents. There is a policy on staff numbers and skills and skill mix is reviewed on a regular basis.

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.

There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses plans and reviews residents' needs, outcomes and goals with the resident and/or

family input. Care plans viewed are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines and complete annual medication competencies. Medication charts are reviewed three monthly by the GP.

The diversional therapist and activity team coordinate and implement the activity programme. Care staff coordinate activities in the dementia care unit. Activities offered meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations. Residents interviewed were satisfied with the activities offered.

All meals and baking are done on site by qualified chefs. The menu has been reviewed by a dietitian. Resident preferences and dislikes are accommodated. Nutritious snacks are available 24 hours. Residents interviewed responded favourably to the food that was provided.

Safe and appropriate environment

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

There is a current building warrant of fitness. Chemicals are stored safely throughout the facility. All rooms are single and have ensuites. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate, and toilet/shower facilities are constructed for ease of cleaning. There are spacious lounges and dining areas in each unit. The dementia unit allows for safe wandering and areas for group or individual activities. Resident rooms are spacious and allow for safe movement of staff and mobility equipment. Cleaning and laundry services are monitored through the internal auditing

system. Systems and supplies are in place for essential, emergency and security services. There is a first aider on duty at all times.

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

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently two residents on restraint, and two residents were using enablers. Restraint assessment and consent procedure were completed for these residents and this process is undertaken by the clinical manager. Staff are trained in restraint minimisation and management of challenging behaviour.

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 clinical manager undertakes infection control activities. There are infection control policies and procedures to guide practice. There is an infection control programme that is reviewed annually, and staff receive ongoing training. Infection control practices are monitored through the internal audit programme. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

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	44	0	3	3	0	0
Criteria	0	95	0	3	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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Jack Inglis Friendship Hospital (JIFH) implements the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) and has policy and procedures in place. Discussions with staff (six caregivers, two registered nurses (RNs), one diversional therapist, a cook, a laundry staff, two cleaners and the chef) confirmed their familiarity with the Code. Interviews with seven residents, including four at rest home level and three at hospital level care, and nine relatives (one dementia, five hospital and three rest home level care) confirmed that the services being provided are in line with the Code. Code of rights training has been provided in 2018 and the most recent training in May 2019.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give	FA	The service has in place a policy for informed consent. General consents had been signed in the eight resident files reviewed (three rest home including one respite care and one younger person under ACC contract and three hospital level residents including one younger person with a physical disability and two dementia care residents). Permissions granted were also included in the admission agreements which had been signed for all residents, including the respite care resident. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Resuscitation status has been signed by the competent resident or where the resident is deemed

informed consent.		incompetent the GP makes a medically indicated resuscitation decision in discussion with the EPOA. Advance care plans and enduring power of attorney (EPOA) where available are held in the resident file. The advance care plan document is included in the admission pack. The EPOA had been activated in the two dementia care files reviewed.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	An advocacy policy and procedure included how staff can assist residents and families to access advocacy services. Contact numbers for advocacy are in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any). Discussions with families identified that the service provides opportunities for the family/EPOA to be involved in decisions. Residents are provided with a copy of the Code and information about advocacy services on entry. Interviews with the quality assurance manager and the clinical manager confirmed that this occurs. Interviews with residents confirmed that they are aware of their right to access advocacy and that there are opportunities to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Interviews with residents and families confirmed that visiting can occur at any time. Family members were seen visiting on both days of the audit. Key people involved in the resident's life are documented in the care plans. Discussions with residents and relatives verified that they are supported and encouraged to remain involved in the community. Entertainers are invited to perform at the facility. Interviews with staff confirmed that residents are supported and encouraged to remain involved in the community.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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. The complaint forms are available at the entrance to the facility. A complaints register included seven complaints since January 2019 and two of these complaints were remain open. The complaints register included both verbal and written complaints. Communication with the complainant is maintained in the folder and all complaints reviewed were thoroughly investigated, and the outcome was reported back to the complainant. The register included resolution and/or outcome of the complaint. Staff have been informed about the complaints and these were included in the investigation process.

		Feedback is provided to staff on the complaints through meetings and the Board is also informed through monthly reports. Residents and family interviews confirmed that they were aware of the complaints process and this was discussed with them on entry to the service. 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.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Information is provided to residents and family members, and includes the Code, complaints and advocacy information. Residents and relatives confirmed this on interview. The CEO provides an open-door policy for concerns or complaints. Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. Monthly resident and family meetings have been held and residents interviewed agreed that the service always responds to issues raised and staff respect their rights.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Interviews with staff, residents and families confirmed that residents are given support and encouragement to maintain their independence. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms. Appropriate signage and locks are on toilet and shower doors. Discussion with the management team confirmed that the service has zero tolerance to abuse and neglect. Prevention, detection and removal of abuse training was provided in 2018 and rescheduled for 2019. Staff are trained to report any concerns and could describe aspects of abuse and neglect. Instructions are provided to residents/families on entry regarding responsibilities around personal belongings in their admission agreement. Personal belongings were seen in resident rooms. The service encourages residents to have choice where able, such as voluntary participation in daily activities. Interview with laundry staff confirmed that personal laundry bags were introduced for management of personal laundry. Staff and management follow up any issues related to missing laundry.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as	FA	On the day of the audit, one resident identified as Māori. This Māori resident has an individual care plan that identifies cultural needs specific to that person. These are based on comprehensive assessments and consultation with the resident and their whānau. The service has advised that they have strong

Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.		connection with local kaumātua who attend JIFH for staff and Māori residents for support and blessing of rooms post deaths. The service maintains a close working relationship with Te Piki Oranga, the Māori health provider attached to Te Awhina marae. Interviews with residents and families confirmed that the service provides a culturally safe service.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	A culturally appropriate service includes assessing residents' needs on entry to the service. Eight residents' files reviewed identified that individual preferences, including cultural and spiritual values, were identified on admission and then integrated into the residents' care plans. Families are invited to be part of the care planning process and are given the opportunity to be involved in all aspects of care delivery. Residents interviewed expressed their satisfaction with the services they receive.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Job descriptions include responsibilities of the position. Signed copies of employment documents were sighted in all nine staff files reviewed. The enrolled nurse works under the direction and delegation of the RNs. There are appropriate policies to guide staff practice. Interviews with staff confirmed their understanding of the code of conduct. Training around professional boundaries and the Vulnerable Person Act are provided to staff in March – April 2019. The service ensures that all staff complete these training activities. The service has guiding documents for staff to ensure residents are free from discrimination and exploitation - staff interviews verified an understanding of the code of conduct. Regular training around the Code is being offered, and attendance records were maintained. Interviews with residents and families reported no discriminatory practices.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	There is a regular in-service education and training programme for staff meeting contractual requirements. The service has maintained strong links with the local community. Residents interviewed spoke positively about the care and support provided. Care staff interviewed have a sound understanding of the principles of aged care and stated that they are supported with their ongoing professional development. Registered nurses can access external training. Policies and procedures are up to date. A quality improvement programme is in place. The resident satisfaction surveys are completed annually and residents and family recommendations around quality initiatives are being acted upon; for example, meal services are reviewed, and the menu has been audited by a

		dietitian. Improvements have been made around maintenance of external areas. There are implemented competencies for caregivers and RNs.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	An open disclosure policy guides staff in their responsibility to notify family of any accident/incident that occurs. Accident/incident forms include a section to indicate if family have been informed (or not) of an accident/incident. Twelve incident forms reviewed identified that families were notified following an adverse event. Interviews with RNs and caregivers confirmed that families are kept informed. There is an interpreter policy and staff are aware of how to access interpreters if required. The recent satisfaction surveys show 93% satisfaction around communication. There are documented two monthly resident meetings for rest home and hospital residents and families, and three monthly in the dementia unit. Meeting minutes show that a variety of issues are discussed and resolved in these meetings. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Jack Inglis provides dementia, rest home and hospital level of care for 77 residents with 62 dual service beds (hospital and rest home). There are ten beds in the secure dementia unit. Occupancy on the first day of audit was 62 residents, including 10 residents in the secure unit, 20 residents receiving hospital level care (including one resident under the young persons with disability contract), 32 residents receiving rest home level of care (including one resident under an Accident Compensation Corporation contract, and one resident under respite care). The service also has a day care contract, and three primary care beds which were vacant on both days of audit. The service has a documented vision, mission statement, philosophy and values. There is a strategic plan 2015-2020 and a business plan 2019-2020. The Trust Board is responsible for governing the facility and the Board meets monthly. The board appointed a new CEO in early 2019. The CEO has over 20 years working in health management/leadership positions including, aged care, private and public hospitals. She an RN and maintains her current practicing certificate. She is supported by the quality assurance manager and the CM. The quality assurance manager is an RN with previous experience as a district nurse working with palliative care and Tui Ora Māori Health. The clinical manager has six years of aged care experience and has undertaken a post graduate diploma in gerontology. The CM has recently resigned and is

		working her notice period until early June. She will continue to work with JIFH as a clinical nurse leader. The management team have completed at least eight hours of training relevant to managing a hospital.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	In the absence of the CEO, the quality assurance manager shares the role of standing in for the CEO. The quality assurance manager is an RN with previous experience as a district nurse working in the field of palliative care and Tui Ora Māori Health.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate	JIFH has a quality and risk management plan which is designed to monitor contractual and standards compliance. There is a quality assurance manager who works 32 hours a week and is responsible for implementation of this programme and works closely with the management team and staff. Policies and procedures are up to date and reviewed by the management team, and external advice is obtained as required. Monthly reports are presented to the Board and these include (but are not limited to); a) health and safety, b) incidents and accidents, c) complaints, d) training, e) audit outcomes, and f) satisfaction survey results. JIFH was previously using a NZ based benchmarking programme, however the membership has been discontinued since February 2019. Clinical meetings occur weekly and individual residents are reviewed in this meeting. Hub meetings are daily, and all staff are invited to this meeting. This ensures communication between different wings. There are a number of meetings, such as staff meetings (six weekly), IC meetings (three monthly), RN meetings (monthly), quality improvements management meetings (monthly) and health and safety meetings (six weekly). Call bell monitoring is completed regularly, and results were presented and discussed in the quality improvement management meetings. April meeting minutes show a reduction in call bell usage by residents from 25% to 17%. Data around falls, and information related to falls prevention are discussed at various meetings. Falls data is being analysed and corrective actions have been implemented where required. Infection Control (IC) data is being analysed and reviewed monthly. A comprehensive report was presented at the quality improvement and management meetings. Complaints are a standing agenda item in the quality

		improvement management meetings and staff meetings. Pressure injury data and prevention of PIs were also discussed in these meetings. A resident and family/whānau survey was completed in March 2019 and survey results have been communicated to staff, residents and families. Satisfaction survey results showed high satisfaction in many areas of service delivery, and individual comments related to improvements to the service, have been listed and consequently improvements have been made. The internal audit programme is implemented. Following completion of internal audits, corrective action plans have been documented, and resolution of issues were completed by the quality assurance manager. Implementation of corrective actions required by the clinical manager remains open (link1.2.8.1.) and all other corrective actions were addressed. The health and safety role was reassigned to the clinical nurse leader who has relevant training to undertake this role. The health and safety programme is not fully implemented.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The service documents and analyses incidents, accidents and provides feedback to staff so that improvements are made. Individual incident/accident reports were completed for each incident/accident with immediate action noted and any follow-up action required. A sample of twelve adverse event forms (February to May 2019) were reviewed. All forms were fully completed and signed off by management. Each event involving a resident had a clinical assessment and was followed up by an RN. Neuro observations were completed following unwitnessed falls with suspected head injury. Falls data has been separately analysed, and corrective actions were 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. All events have been reviewed, and data was discussed at several meetings including quality improvement management meetings and staff meetings. The service analyses the trends, and a comprehensive report is completed that includes outcomes and further actions required at a facility level. A regular review is completed of frequent falls. Interviews with the quality assurance manager confirmed awareness of their requirement to notify relevant authorities in relation to essential notifications. A section 31 notification was completed for a pressure injury.
Standard 1.2.7: Human Resource Management	PA Low	There are human resource management policies. A copy of practising certificates is kept. Nine staff files were sampled (the clinical nurse leader, the quality manager, an RN, an enrolled nurse, a

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		DT, three caregivers and one cook). All files reviewed contained documentation relating to evidence reference checking, completion of an orientation programme and job descriptions. Annual appraisals were completed for all staff who had been employed for more than twelve months. Current annual practicing certificates are kept on file. JIFH has a comprehensive training plan in place and in the last 12 months, a priority was given for increased training around consumer rights, professional boundaries, communication and the aging process. There are implemented competencies for RNs and ENs, related to specialised procedure or treatment including (but not limited to) medication management and syringe driver training and competencies. Senior caregivers also complete medication training and competencies. Residents and families stated that staff are knowledgeable and skilled. There is an evidence of staff completing external training. There is an improvement required around full implementation of the training programme. Staff who work in the dementia unit have completed dementia specific training within required timeframes and one staff is awaiting her last papers to be marked. Seven staff works in the dementia unit, six have completed their training and one is waiting for the last paper to be marked. There are nine RNs and a clinical manager and a clinical leader. Six RNs were interRAI trained and one was undertaking training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Moderate	There is an appropriate staff rationale and skill mix policy in place. Sufficient staff are rostered on to manage the care requirements of the residents. The service is advertising for caregivers' vacancies and two RNs are waiting for work visa approval. RN shortages are covered by the CM, and planned paperwork for RNs were not covered due to RN shortages. The CM has resigned from her current position and will be stepping into the clinical nurse leader position. Recruitment towards the CM position has not commenced yet.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The residents' files are appropriate to the service type. Residents entering the service have relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is developed in this time. The RNs have completed interRAI assessments for all the residents who have been at the facility longer than three weeks. Medication records were maintained electronically, and all other residents' information was paper-based. Individual resident files demonstrate service integration. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Archived records are stored securely.

Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry for short-term stays, rest home, and hospital and dementia level of care services. The information pack includes specific information on dementia care and the secure environment. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Policy describes guidelines for death, discharge, transfer, documentation and 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. Communication with family occurs.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. 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 by the pharmacist. The RN checks incoming medication blister packs against the electronic medication chart and signs a paper-based verification form and the back of the blister pack when the packs have been checked. Medication is stored safely within the three units. Expiry dates for 'as required' medications and bulk supply order (for hospital level residents only) are checked monthly by the RN. All medications were within the expiry dates. Eye drops had been dated on opening. Medication fridge temperatures are monitored and recorded daily with temperatures within the acceptable range. There was one rest home resident self-medicating with a self-medication assessment, weekly monitoring and safe storage for inhalers. The GP reviews the self-medication competency three monthly. All 16 medication charts reviewed 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 effectiveness of 'as required' medication was recorded on the electronic medication chart and in the resident progress notes.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	A chef manager manages and oversees the food service at the facility. She is supported by morning and afternoon kitchenhands. The service also provides meals on wheels to the community. The food control plan has been verified and expires 30 June 2019. The four-week menu has been reviewed by a dietitian and the chef manager is in the process of implementing recommendations including resident preferences. The main meal is at midday. 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 including fruit platter are available 24 hours in the dementia unit. 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. A daily checklist is completed, which includes fridges, freezer and chiller temperatures, end-cooked food (twice daily), cooling temperatures, chilled/frozen goods on delivery and dishwasher rinse and wash temperatures. The chemical provider completes a monthly function check on the dishwasher. All perishable goods were dated, as were the dry goods in the pantry. A cleaning roster is maintained for cooks and kitchenhands. All staff have completed training in food safety and hygiene. Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. The chef manager attends resident meetings and serves meals in the hospital dining room. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. 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.
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 as evidenced for one rest home resident on return from a hospital admission. InterRAI assessments have been completed for the younger person under ACC and the younger person with a physical disability.

		Resident needs and supports identified through the assessment process, allied health notes, discharge summaries and information gathered from the resident/relative, 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.
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. Support needs for identified risk or changes to care had not always been documented in the care plans for six of eight resident care plans reviewed. Short-term care plans had been utilised for short-term needs such as weight monitoring, wounds, pressure injury, and infections. Short-term care plans are reviewed and if an ongoing problem, added to the long-term care plan. Behaviour management (action) plans were in place for the two dementia care files reviewed 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, occupational therapist, assessment, treatment and rehabilitation team, speech language therapist, dietitian, geriatrician, mental health services and specialist physician for younger people.
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 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 are in place. Wound assessments, treatment, evaluations and photos were in place for 11 residents across the facility with wounds (skin tears, lesions and chronic wounds). There were three pressure injuries (two unstageable and one stage three) on the day of audit. Two pressure injuries (one unstageable and one stage three) were present on admission and one unstageable pressure injury of the heel was facility acquired. There were pressure injury devices readily available and in place for the three residents. A senior RN with previous experience and postgraduate papers for surgical wounds is the wound resource nurse for the service. There is access to a district nurse for advice and support as

		required. The GP reviews the wounds regularly. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Monitoring occurs for weight, vital signs, blood glucose, pain, repositioning, food and fluid intake, neurological observations, and challenging behaviour.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service has a full-time qualified diversional therapist (DT) who oversees the activity team of a part-time (two days per week) activity coordinator and part-time activity assistant. There are a number of volunteers involved in the activity programme. There are two activity choices available for residents on four weekdays when there are two activity staff on duty. Care staff assist residents to attend activities of their choice within their unit or to a combined activity. The rest home/hospital programme has integrated activities and residents receive a large print copy for their rooms. The programme also identifies activities that are suitable for the under 65 years of age residents. The service also runs a day care programme. Caregivers who work in the dementia unit incorporate activities into their role as observed on the day of audit. The programme is planned to reflect the cognitive and physical abilities of the groups of residents. Activities offered include (but are not limited to): a variety of exercises, newspaper reading; board games; quizzes; bowls; petanque, cards, reminiscing; music; happy hours; baking, art, movies; and ice-creams. One-on-one time is spent with residents who are unable to participate or choose not to join in group activities. There are integrated activities such as fortnightly entertainment, movies, church services and guest speakers offered for all residents including dementia care residents (as appropriate) under supervision. Other community visitors include Plunket babies, primary school children, beauty therapist and canine pet therapy. There are weekly outings or scenic drives to places of interest and community groups such as RSA housie. One on one time is spent with the younger people and there are weekly shopping trips. Activities in the dementia care unit are flexible and meaningful for the individual resident and include reminiscing, sing-a-longs, baking, bird feeding, gardening, walks and domestic activities. Volunteers visit and spend one on one time with residents such as reading, chats and walks. 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. 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.

		There is an opportunity for residents and families to provide feedback and suggestions for the programme through bi-monthly 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.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	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 six- monthly against the resident goals, indicating if the goals had been met or unmet. An annual MDT review meeting is held with the family/resident (as appropriate), RN, DT, GP and any allied health professionals involved in the care of the resident. The MDT review record evidenced feedback from the RN, caregiver, DT, pharmacist, GP, physiotherapist, podiatrist, dietitian as applicable and the resident/relative. 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 GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and there were some changes made to care plans (link 1.3.5.2).
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the physiotherapist, dietitian, and geriatrician, mental health services for older people, urology, diabetes nurse and palliative care consultant. Discussion with the 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. There was evidence of referral to the need's assessment team for re-assessment of level of care from rest home to hospital level of care.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Chemicals are dispensed through a pre-mixing system. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. Staff were observed wearing appropriate personal protective clothing when carrying out their duties. A chemical spills kit is available.

Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current warrant of fitness that expires 29 September 2019. There is a full-time maintenance manager and part-time assistant who actions daily requests for maintenance and repairs and completes the monthly planned maintenance programme. There is a maintenance request record kept at the main entrance. Repairs are signed off as completed. Essential contractors are available when required. Electrical equipment has been tested and tagged. The hoists, scales and clinical equipment is checked/calibrated annually. Hot water temperatures have been monitored monthly and were within the acceptable range. The corridors are wide and promote safe mobility with the use of mobility aids or transferring residents to communal areas in hospital lounge chairs. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained with seating and shade available. The rear car park has been resurfaced and there is safe paving allowing for residents to take a walk around the block with seating available for a rest along the way. The car park provides a safe area for resident mobility scooter training (as requested by residents) under supervision. The dementia unit garden and grounds are safely fenced. There are two doors off the lounge that allow for free access to the garden area with walking pathways, seating and shade. There is safe access to all communal areas in the dementia care unit. Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home, hospital and dementia level of care residents.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	Resident rooms within the facility have ensuites. Four rooms have shared ensuites. The three primary care beds are standard rooms with a communal shower/toilet room close by. There are privacy signs on all toilet/bathroom doors. Fixtures, fittings and flooring are appropriate for ease of cleaning. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. One large bathroom has a hydrotherapy bath. Rest home and hospital residents interviewed confirmed staff respected their privacy when carrying out hygiene cares.
Standard 1.4.4: Personal Space/Bed Areas	FA	There is sufficient space in all residents' rooms to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		residents. Residents are encouraged to personalise their bedrooms as viewed on the days of audit.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The hospital unit has an open plan dining and lounge area and seating alcove in the front reception area. The rest home area has a separate dining and lounge area where activities occur. There is safe access to all communal areas and external gardens and grounds. The dementia unit has a spacious open plan dining and lounge area with safe access to the secure garden and grounds. Each unit has a kitchenette area. The kitchenette area in the dementia unit has a barrier door for resident safety. The whānau room has tea/coffee making facilities. There is a hairdresser salon for the visiting hairdresser to use.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are documented systems for monitoring the effectiveness and compliance with the service's policies and procedures. All laundry is done on site in a laundry located in a separate building on the site. The laundry operates from 7 am to 3 pm seven days a week. The full-time and part-time laundry workers have completed chemical safety training and infection control in-service. There is a defined clean/dirty flow with an entry and exit door. There is a separate drying room and adequate bench space for folding of linen. There are two full-time cleaners on duty Monday to Friday to complete cleaning duties for the facility. There is one cleaner on duty in the weekends to complete a basic clean for the facility. Cleaning staff have completed chemical safety training and Careerforce level three for cleaning. Cleaning trolleys sighted were well equipped and all chemicals labelled correctly. Personal protective equipment is available. The cleaners' trolleys when not in use, were stored in locked areas at each end of the facility. The chemical provider monitors the cleaning and laundry service and chemical use and effectiveness each month. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the facility.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security	FA	Emergency and disaster policies and procedures are in place. Fire evacuation drills take place every six months. The orientation programme and education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. An approved fire evacuation plan is in place. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency

situations.		including food, water, blankets and the availability of gas cooking. A back up battery for emergency lighting is in place. Resident's call bell monitoring occurs, and call bells can be accessed in all resident rooms, toilets, communal areas including dining areas. Residents and family reported that staff answer call bells in a timely manner. Emergency lighting and cooking is available in the event of a power failure. Security procedures are established. There is a first aid certified staff member on duty at all times.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All resident bedrooms have external windows with plenty of natural sunlight. The facility has underfloor heating which can be adjusted individually from the main panel. There are windows and doors that open for ventilation.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The Infection Control (IC) programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The infection programme was last reviewed in June 2018. The IC programme description is available. There is a job description for the IC coordinator which includes clearly defined guidelines and responsibilities. The IC issues and surveillance data is disused in the quality improvement management meetings. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Hand hygiene notices are in use around the facility. Residents and staff are offered the influenza vaccine.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the	FA	The CM is the designated IC coordinator who has completed external IC training. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator has good external support from the public health authorities, an external IC consultant and the local DHB. The IC team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.

organisation.		
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The IC policies and procedures defines roles, responsibilities, oversight, the IC team, training and education of staff. IC policies are supported by the Bug Control NZ and the service maintains the most up to date documents.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	JIFH is committed to the ongoing IC education for staff and residents. Formal IC education for staff has occurred and is part of the annual education programme. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. IC education is provided by the IC coordinator who maintains the most up to date knowledge.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The IC surveillance programme is implemented. The programme is appropriate to the size and complexity of the facility. Monthly infection data is collected for all infections, based on signs and symptoms of infection. An individual resident infection form is completed, and short-term care plans are used. Outcomes and actions of IC episodes are discussed at quality improvement management meetings. If there is an emergent issue, it is acted upon in a timely manner. GP interview confirmed prompt notification of individual infections cases. The electronic medication system is also used in monitoring and review of IC data. There has been no outbreak since September 2018.
Standard 2.1.1: Restraint minimisation Services demonstrate that the	FA	The service has policies and procedures on restraint minimisation and safe practice, and there are documented definitions of restraint and enablers. The CM is the restraint coordinator. There are two residents on restraint (bed rails) and two residents are using enablers (one lap belt and one bedrails) on

use of restraint is actively minimised.		the day audit. These residents are hospital level care. Restraint assessment and consent procedures were completed for these residents and this process was undertaken by the CM. Two files reviewed showed that restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of enablers. Challenging behaviour training was last completed in September 2019.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	Staff maintains competency assessments. The restraint coordinator is the CM and she has a signed job description and understands the role and her accountabilities, and this was confirmed on interview. The assessment and approval process for restraint involves the restraint coordinator, the resident and/or their representative/whānau and the GP.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments are completed by the CM or the RN on duty. The restraint coordinator has a job description in place. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment and enabler assessment tool available and completed for the residents requiring restraint for safety. Two files reviewed for restraint minimisation, including restraint and enabler, showed that the care plans were up to date and provided the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau was also identified and documented. The assessment form considered those items listed in 2.2.2.1 (a) - (h) and these aspects were reviewed three monthly.
Standard 2.2.3: Safe Restraint Use	PA Low	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is responsible for completing all the documentation. The approval process includes ensuring the

Services use restraint safely		environment is appropriate and safe. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or whānau, the GP and the restraint coordinator. Monitoring and observation process is included in the restraint policy. Each episode of restraint is planned to be monitored at least at two hourly intervals, but this is not always completed in timely manner. A restraint register is in place, which has been completed for the residents requiring restraint and enablers.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred monthly as part of the ongoing reassessment for the resident on the restraint register, and as part of their care plan review. The family was included as part of this review. A review of two resident's files identified that evaluation is up to date.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	PA Low	Restraint use is individually reviewed at least three monthly through the medical reviews. Staff were informed about this through handovers. Staff interviews confirmed that they were informed about review of individual restraint use. However, quality review of restraint use has not been fully documented as completed.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.9 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: (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; (b) A process that	PA Moderate	Quality review of the health and safety programme was completed in October 2018. This includes all aspects of the programme and comments towards achieving full compliance. There is a health and safety policies and procedures and a hazard and risk register. However, new hazards have not been identified and included in the register to ensure strategies are implemented to minimise, eliminate or isolate. Health and safety meetings occur six weekly and include only management team members. The health and safety committee is not	(i) The health and safety committee does not have representation of all staff, and only includes the management team. (ii) New hazards have not been identified and included in the register to ensure strategies are implemented to minimise, eliminate or isolate.	(i) Ensure that the health and safety committee includes staff representation. (ii) Ensure that the hazard register includes all identified hazards. 90 days

addresses/treats the risks associated with service provision is developed and implemented.		representing the service providers within the JIFH. Contractor inductions have been completed.		
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	The previous training manager has resigned from her position and the clinical leader has undertaken this role. JIFH has a comprehensive training plan in place and in the last 12 months, a priority was given for increased training around consumer rights, professional boundaries, communication and aging process. A high number of training participation and repetitive training sessions were noted in the training records on these identified subjects. There are implemented competencies for RNs and ENs related to specialised procedure or treatment including (but not limited to) medication management and syringe driver training and competencies. Senior caregivers' complete medication training and competencies. Staff training records showed that training related to clinical and environment had low participation and not all staff had completed a minimum of eight hours training.	Ensure that staff complete at least eight hours training a year.	Ensure that staff maintain a minimum eight hours training. 180 days
Criterion 1.2.8.1 There is a clearly documented and implemented process which	PA Moderate	JIFH employs 92 staff in various roles. An electronic staffing roster is used. The clinical manager	The clinical manager has resigned from her current position but is still in the position and has current responsibility for clinical supervision. The	Ensure that the clinical manager

determines service provider levels and skill mixes in order to provide safe service delivery.		works full time, Monday to Friday and is based in the Magnolia and Camelia wing and provides oversight to the whole facility. The clinical leader in the dementia unit works three days a week and an additional day for health and safety and training. The dementia unit has 10 bed capacity and occupancy on the day of audit was at 10. The roster included two caregivers in the morning and afternoon duties and one caregiver at night. Magnolia and Camelia wings have 38 beds (including three primary care beds) and on the day of audit, there were 29 residents (12 rest home and 17 hospital level care residents). The roster included 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 shifts, one x five hours and one x six hours). There are two caregivers rostered at night. There is at least one RN rostered 24 hours a day. Gardenia wing has 29 beds and on the day of audit, there were 23 residents (21 rest home and two hospital level care residents). The roster included four caregivers in the morning (two x five-hour shift and two x eight-hour shift), three in the afternoon (two x eight hours	recruitment process is in planning stages. There are number of corrective actions around service delivery. This is work in progress. The CM is already covering RN shortages/sick leave until two RNs obtain work visas'. The current RN team is young and requires support and supervision. Furthermore, this audit identified several clinical findings around care planning that requires follow up. Therefore, auditors considered these issues and determined that the clinical manager role is critical for the optimum service delivery and leadership	position is replaced in a timely manner and clinical supervision continues to be maintained. 60 days

		and one x five hours shift). There is an RN or EN rostered in the morning and afternoon duties. There are dedicated administration, kitchen, maintenance, laundry and cleaning staff. The roster shows an additional RN for a paperwork day, but this has not been covered. A review of three weeks roster showed that the CM had covered RN shifts at least once a week during these roster periods and on interview she confirmed this. Staff interviews confirmed that staff shortages were covered. Staff, resident and family interview did not raise any concerns around staffing levels. There are three caregivers' roles vacant and these positions are currently being advertised. Two RNs were recruited but waiting for a work visa. The clinical manager had already resigned from her position and will step down to a new role as a clinical nurse leader in early June 2019. The CEO stated that it will be an internal position review process/restructuring, however this process has not commenced yet and/or the clinical manager position has not been advertised.		

Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	The long-term care plans described supports and needs for daily activities of living, however, not all interventions had been documented for changes to risk assessments and changes of health in six of eight resident files reviewed.	(i) There was no diabetic management plan in place for the rest home respite resident who was an insulin dependent diabetic. (ii) Rest home younger person under ACC was assessed at high risk of falls, however, the care plan did not reflect falls prevention strategies for high falls risk. The same resident did not have any documented interventions for hip pain post fall, requiring GP treatment and analgesia. (iii) Another rest home resident did not have a documented pressure injury prevention plan for moderate risk of pressure injury as assessed on return from hospital. Choking risk was not identified on the care plan. (iv) The hospital level younger resident with a physical disability was assessed at high risk of pressure injury but there were no interventions for high risk documented in the care plan. There was no short-term care plan in place for an infection being treated. There was no link in the care plan of health professionals involved in the resident's care. (v) There were no documented interventions or implementation of interventions for a hospital resident with significant weight loss and (vi) There was a STCP in place but no initial pain assessment documented for a dementia care resident with neck pain requiring GP and physiotherapist treatment and analgesia.	Ensure interventions are documented to meet the resident support and needs. 60 days
Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use,	PA Low	Restraint and enabler monitoring includes the areas identified in 2.2.3.4 from (a) to (g), but restraint and enabler monitoring were not consistently documented as	Restraint and enabler monitoring records were incomplete and there were gaps in monitoring forms from six hours to two days.	Ensure that restraint and enabler monitoring is completed as

intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.		completed.		planned. 90 days
Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an	PA Low	Meeting minutes showed limited information and no discussion around restraint and enablers. Some meetings only included numbers of restraints and enablers in use. JIFH used a restraint audit form to complete a quality review of restraint minimisation activities, however, this was a tick box audit form which showed full compliance and did not include comments around the restraint minimisation process and any incident and	The organisation-wide quality review of restraint use does not identify a thorough review of restraint minimisation practises.	Ensure that a thorough quality review of restraint minimisation occurs, and that it considers all components listed in this criterion.

appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education.		accidents during the last 12-month period.		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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.