FOMHT Health Services Limited - Jack Inglis Aged Care Home

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Ngā paerewa Health and disability services standard (NZS8134:2021).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to Manatū Hauora (the Ministry of Health).

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā paerewa Health and disability services standard (NZS8134:2021).

You can view a full copy of the standard on the Manatū Hauora website by clicking here.

The specifics of this audit included:

Legal entity:	FOMHT Health Services Limited
Premises audited:	Jack Inglis Aged Care Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 4 December 2025 End date: 5 December 2025

Proposed changes to current services (if any): In accordance with the letter from HealthCERT dated July 2024 the service was verified and confirmed suitable to have 64 dual purpose beds. The increase by three beds (to include the one GP and two respite beds) in the dual-purpose beds has resulted in total bed capacity of 77 beds (64 dual-purpose and 13 dementia level care beds).

Total beds occupied across all premises included in the audit on the first day of the audit: 77

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 sections contained within the Ngā paerewa Health and disability services standard:

- ō tātou motika │ our rights
- hunga mahi me te hanganga │ workforce and structure
- ngā huarahi ki te oranga │ pathways to wellbeing
- te aro ki te tangata me te taiao haumaru │ person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita │ infection prevention and antimicrobial stewardship
- here taratahi │ restraint and seclusion.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the subsection in each of the sections. 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 subsections applicable to this service fully attained with some subsections exceeded
	No short falls	Subsections 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 subsections applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some subsections 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 subsections applicable to this service unattained and of moderate or high risk

General overview of the audit

Jack Inglis Aged Care Home (Jack Inglis) provides rest home, hospital (medical and geriatric), and dementia levels of care for up to 77 residents. There were 77 residents on the days of audit.

This surveillance audit was conducted against a subset of the Ngā Paerewa Health and Disability Standard 2021 and contracts with Health New Zealand. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family/whānau, management, staff, and general practitioner.

The chief executive officer is appropriately qualified and experienced and is supported by a clinical manager and a quality manager (registered nurse).

There are documented quality systems and processes. Feedback from residents and family/whānau was positive about the care and the services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

The previous audit findings related to satisfaction surveys, meetings, staff training; monitoring; and infection control have been satisfied.

This surveillance audit identified shortfalls related to reporting, care plan interventions, and medicine management.

Ō tātou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Subsections applicable to this service fully attained.

A Māori health plan is in place for the organisation. Māori mana Motuhake is recognised in all aspects of service delivery, using a strengths-based and holistic model of care. Staff encourage participation in te ao Māori.

A pacific health plan is in place which ensures cultural safety for Pacific peoples, embracing their worldviews, cultural and spiritual beliefs.

Policies are in place around the elimination of discrimination, harassment, and bullying. Consent forms are signed appropriately. There is an established system for the management of complaints that is responsive, fair, equitable and meets guidelines established by the Health and Disability Commissioner.

Hunga mahi me te hanganga | Workforce and structure

Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Some subsections applicable to this service partially attained and of low risk.

The business plan includes a mission statement and operational objectives. The service has a quality and risk management system in place that take a risk-based approach. Quality improvement projects are implemented. Internal audits, and collation of data were all documented as taking place as scheduled, with corrective actions as indicated.

There is a staffing and rostering policy that aims to manage human resources in accordance with good employment practice. An orientation programme and staff training plan are in place to support staff in delivering safe quality care.

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Registered nurses assess residents on admission. InterRAI assessments and risk assessments are used to identify residents' needs, and long-term care plans are developed and implemented. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. The service has a current food control plan.

Medication policies reflect legislative requirements and guidelines. The registered nurses and medication competent caregivers are responsible for administration of medicines. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner.

Discharge and transfers are coordinated and planned.

Te aro ki te tangata me te taiao haumaru | Person-centred and safe environment

Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.		Subsections applicable to this service fully attained.

The building has a current warrant of fitness. A maintenance plan is adhered to, and all equipment is tagged, tested, and calibrated as scheduled. The dementia unit is secure.

Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

Includes five subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.		Subsections applicable to this service fully attained.

There is a comprehensive infection control programme in place which has been approved and reviewed by the senior management and the board. Staff complete education in relation to infection control during orientation and as scheduled.

Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. There have been no outbreaks recorded and reported on since last audit.

Here taratahi | Restraint and seclusion

Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Subsections applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the clinical lead. At the time of the audit there were no residents using restraints. Staff demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-escalation techniques, and alternative interventions.

Summary of attainment

The following table summarises the number of subsections 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)
Subsection	0	15	0	1	2	0	0
Criteria	0	46	0	1	2	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)
Subsection	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	A Māori health plan is documented for the service, which Jack Inglis utilises as part of their strategy to embed and enact Te Tiriti o Waitangi in all aspects of service delivery. As part of staff training, Jack Inglis incorporates the Māori health strategy (He Korowai Oranga) and Te Whare Tapa Wha Māori model of health and wellbeing into practice. They also discuss the importance of the Treaty of Waitangi and how the principles of partnership, protection and participation are enacted in the work with residents. The service currently has residents and staff who identify as Māori. The service recognises Māori mana Motuhake, and this is reflected in the Māori health plan.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews	FA	There is a Pacific health plan which aligns to Ola Manuia Pacific Health and Wellbeing Action Plan 2020-2025. The aim is on fostering Pacific community integration and collaboration to enable better planning, support interventions, and evaluations of the health and wellbeing of Pacific peoples to improve outcomes. At the time of the audit there were residents and staff who identified as Pasifika and supported the service in understanding worldviews, cultural and spiritual beliefs of Pacific peoples.

and developed in collaboration with Pacific peoples for improved health outcomes.		
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in English and te reo Māori. The chief executive officer and clinical manager demonstrated how it is also given in welcome packs in the language most appropriate for the resident to ensure they are fully informed of their rights. Interviews with four family/whānau (one rest home, two dementia and one hospital level), and four residents (three hospital level, one rest home level) confirmed they are informed of their rights and their choices are respected. Interactions observed between staff and residents during the audit were respectful.
Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	Jack Inglis policies provide guidelines that aim to prevent any form of institutional racism, discrimination, coercion, harassment, or any other exploitation. A comprehensive code of conduct is discussed and signed by staff during their induction to the service. The code of conduct addresses harassment, racism, and bullying. Staff sign to acknowledge that they accept the code of conduct as part of the employment process. All family/whānau interviewed confirmed that the staff are very caring, supportive, and respectful. The service implements a process to manage residents' comfort funds, such as sundry expenses. Professional boundaries are defined in job descriptions. Interviews with registered nurses and caregivers confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation. Interviews with eleven staff (three caregivers, one enrolled nurse, five registered nurses [including one clinical nurse lead and one nurse educator / dementia unit coordinator], one cook and one maintenance staff), the chief executive officer, clinical manager, quality coordinator, residents, family/whānau and documentation reviewed, confirmed that the staff are very caring, supportive, and respectful.

Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.	FA	There are policies to guide the informed consent process. Resident files reviewed included completed general consent forms and consents for influenza and Covid-19 vaccinations, release of photographs and the use of comfort funds. Residents and family/whānau interviewed could describe what informed consent was and knew they had the right to choose. Consent forms were appropriately signed by the activated enduring power of attorney (EPOA) where this has been activated. All documentation regarding EPOA, and activation is on file, as reviewed and available in the files of the residents residing in the dementia unit.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	The complaints procedure is provided to residents and family/whānau during the resident's entry to the service. Access to complaints forms is located at the entrance to the facility or on request from staff. The Code of Health and Disability Services Consumers' Rights and complaints process is visible, and available in te reo Māori, and English. A complaints register is being maintained which includes all complaints, dates and actions taken. There has been three internal complaints made in 2025 to date and two complaints made in 2024 including one anonymous complaint (7 October 2024) from Health New Zealand via age concern. This has since been investigated and closure letter dated 21 October 2024 received from Health New Zealand. There have been one death September 2024 which was referred to the coroner. The service has since completed internal investigation and submitted all the required documentation required by the coroner. At the time of the audit there was no outcome received yet from the coroner and as such remains open. Documentation including follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner. There were no trends or patterns

		noted in the themes related to the complaints reviewed. All the internal complaints were closed off to the satisfaction of the complainants. Residents or family/whānau making a complaint can involve an independent support person in the process if they choose. The complaints process is linked to advocacy services. Discussions with residents and a family/whanau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had, were addressed promptly. Information about the support resources for Māori is available to staff to assist Māori in the complaints process. Interpreters contact details are available. The chief executive officer acknowledged their understanding that for Māori, there is a preference for face-to-face communication and to include whānau participation. Staff are informed of complaints (and any subsequent corrective actions) in the staff and clinical quality improvement meetings (meeting minutes sighted).
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	FA	Jack Inglis Aged Care Home (Jack Inglis) is located in Motueka, Nelson Marlborough. In accordance with the letter from HealthCERT dated July 2024 the service was verified and confirmed suitable to have 64 dual purpose beds. The increase by three beds (to include the one GP and two respite beds) in the dual-purpose beds has resulted in total bed capacity of 77 beds (64 dual-purpose and 13 dementia level care beds). There are no double rooms. The facility is a purpose-built facility across one level. Jack Inglis provides care for up to 77 residents at rest home, hospital (medical and geriatric), and dementia levels of care. On the day of the audit there were 77 residents: 34 rest home level residents including two on respite care; 13 dementia level; and 30 hospital residents. With the exception of the two residents on respite care the remaining residents were under the age-related residential care (ARRC) agreement. Jack Inglis has a current strategic plan in place with clear goals to support their documented vision, mission, and values. These include (but not limited to) customer focus; healthy workplace; community connection; physical environment; sustainability; equity and Māori wellbeing. The model of care sits within the strategic framework and incorporates the Māori concept of wellbeing – Te Whare Tapa Wha. The current business plan

		includes a mission statement and operational objectives with site specific goals. The management team report to the chief executive officer (CEO), who liaises with, and acts as a conduit to the Board of directors. Jack Inglis is governed by a Board of directors, which consists of the Board chair, Māori representatives, whānau representative, a doctor (consultant from local hospital), accountant, businesspersons, and a manger from local tertiary institute. The directors are experienced, long standing and strive to support the organisation to meet its goals to support the vision, mission, and values. The Board of directors' meetings are held regularly with attendance from Jack Inglis chief executive officer, who provides a report that includes (but not limited to) complaints; ethnicity data; restraint; pressure injuries; falls; infection control data; staff training; health and safety; audit findings; survey results; budget markings; adverse events; Māori Hauora; and staff retention. The clinical manager and quality coordinator have oversight with clinical governance, and this is supported through the health professionals on the Board. The chairperson is in regular contact with the chief executive officer, with at least weekly visits to the facility. The chief executive officer confirmed that there are community links who provide advice to the directors in order to further explore and implement solutions on ways to achieve equity and improve outcomes for tāngata whaikaha. The working practices at Jack Inglis are holistic in nature, inclusive of cultural identity, spirituality and respect the connection to family, whānau and the wider community as an intrinsic aspect of wellbeing and improved health outcomes for Māori and tāngata whaikaha. The management team and directors have completed cultural training to ensure they are able to demonstrate expertise in Te Tiriti, health equity, and cultural safety. The quality programme includes quality goals that are reviewed two monthly in facility meetings with milestones and progress documented. The service is managed by an experienced chief executive officer (registered nurse) who has been in the current role for 20 months. The chief executive officer has a wealth of experience in aged care and management. The chief executive officer is supported by a clinical manager who has been in the role for over 12 months and with the organisation for over seven years. They are both supported by an experienced quality

		manager (registered nurse), nurse educator/dementia unit coordinator, clinical nurse leads and an experienced care team. The chief executive officer and clinical manager have both completed over eight hours of training in managing an aged care facility, including attending the New Zealand Aged Care Association (NZACA) conference, study days with local Health New Zealand; attending regular ARRC meetings and cultural training related to Te Tiriti o Waitangi, Te Whare Tapa Wha and te ao Māori.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	PA Low	Jack Inglis is implementing a quality and risk management programme. The quality and risk management plan 2024-2026 has documented quality goals that are reviewed ongoing with clear target dates for implementation, responsibilities for implementation and improvement indicators. The plan is discussed ongoing through the staff meetings and the clinical quality improvement meetings. Jack Inglis implements a continuous quality improvement approach with service delivery. Interview with the chief executive officer and quality coordinator confirmed their understanding and involvement in quality and risk management practices. The organisations quality and risk management programme includes performance monitoring through internal audits and through the collection of clinical indicator data. Two monthly clinical quality improvement, health and safety, staff and registered nurse meetings provide an avenue for discussions in relation to (but not limited to): quality data; health and safety; infection control/pandemic strategies; complaints received (if any); cultural compliance; staffing; and education. All the meetings were completed as scheduled and meeting minutes reviewed evidence follow up of actions and sign off when completed. This is an improvement on the previous audit, and the partial attainment relating to HDSS:2021 # 2.2.2 specifically related to staff meetings has been satisfied. Internal audits are completed as per the internal audit schedule. Any corrective actions identified are used to improve service delivery and are being signed off when resolved and discussed at meetings. Quality data is collected, analysed, and discussed at meetings. Resident and family/whanau satisfaction surveys have been completed as scheduled since last audit. With the low return rate observed in the June

		2025 survey the service introduced an on the spot “happy or not” electronic survey process where there is ongoing feedback received. The service loads the machine with specific questions to assess level of satisfaction which run over a two-week period and is completed as residents and family/whanau come and go to the facility. The outcome of the October 2025 satisfaction related to care provision demonstrated 82% satisfaction for rest home and hospital and 95% satisfaction for the dementia family/whanau. Survey outcomes have been communicated to the residents and family/whanau. Corrective actions related to individual comments have been addressed. This is an improvement on the previous audit, and the partial attainment relating to HDSS:2021 # 2.2.2 specifically related to satisfaction surveys has been satisfied. The chief executive officer facilitates resident and family/whanau meetings that occur two-monthly. The service holds separate family/whanau meetings specifically for the dementia unit family/whanau. Minutes reviewed demonstrated issues raised are followed up on, with actions being reported back to the meeting. This is an improvement on the previous audit, and the partial attainment relating to HDSS:2021 # 2.2.2 specifically related to resident and family whanau meetings has been satisfied. Policies and procedures are held electronically and in hard copy. Staff interviewed confirmed they were able to access policies and relevant documentation, as and when required. Each incident/accident is documented electronically. Ten accident/incident forms reviewed indicated that the forms are completed in full and signed off by the clinical manager; opportunities to minimise risk are documented. Incident and accident data is collated monthly and reported in the facility meetings. Health and safety meetings occur two monthly. Health safety goals have been evaluated for 2024/2025 with the new goals developed and shared with all staff for 2025/2026 through meetings and notice board notifications. Hazards and other risks are documented and addressed. Staff have received education related to hazard management and health and safety at orientation, and annually. Discussions with the clinical manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. However, the flood events were not notified as per Section 31 requirements. There have been Severity Assessment Code (SAC) notifications to Health Quality and Safety Commission (HQSC) reported.

		There have been no outbreaks since the previous audit. The clinical manager, on interview was able to explain the reporting requirements with outbreaks.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	FA	There is a staffing policy that describes rostering requirements. Acuity and clinical staffing ratios are described in the policy. Interview with the chief executive officer confirmed that staffing is flexible to meet the changing needs of the residents. The roster reviewed provides sufficient coverage for the delivery of care. The chief executive officer and clinical manager work full time from Monday to Friday. After hours support is provided for clinical and operational issues seven days per week. There is a registered nurse rostered on all the shifts. Vacant shifts are covered by part time staff picking up additional hours and the use of a casual pool. There were no immediate vacant shifts to be filled. In the absence of the chief executive officer or clinical manager the quality coordinator and the nurse educator / dementia unit coordinator provide a plan for cover. The chief executive officer confirmed that staff turnover has been low since last audit. Rosters reviewed and interviews with staff, management, residents and family/whānau confirmed that staffing is adequate to meet the needs of the residents. Review of the current and previous rosters and discussion with staff confirmed that planned and unplanned absences are covered. Good teamwork amongst staff was highlighted during the caregiver interviews. Staff and residents are informed when there are changes to staffing levels as evidence in meeting minutes reviewed. The non-clinical roster reviewed evidence that separate staff are allocated to complete activities, laundry, cleaning, kitchen, administration, and maintenance tasks. An education programme was completed as per schedule in 2024/2025. The education plan is developed and coordinated by the nurse educator / dementia unit coordinator. The education and training schedule lists all mandatory topics. Interview with the nurse educator / dementia unit coordinator confirmed that training is facilitated face to face, online and also by use of external speakers to ensure clinical and non-clinical topics are covered as per schedule. This is an improvement upon the previous audit and the partial attainment related to HDSS: 2021 # 2.3.4 has been met. Staff have been provided with cultural safety training, including Māori

		Health, equity, and Te Tiriti o Waitangi. Education topics included (but not limited to) manual handling; infection prevention and control; challenging behaviour; de-escalation; restraint; nutrition and hydration; skin care; wound management; abuse and neglect; code of rights; falls prevention and management; palliative care; risk management; urinary tract infection and dehydration; pain management; health and safety; and fire safety. The service supports and encourages caregivers to obtain a New Zealand Qualification Authority (NZQA) qualification. There are two registered nurses who are Careerforce assessors and support staff completing their qualifications. Forty of the fifty-one caregivers have completed their level three and above NZQA qualifications. There are eleven caregivers that regularly rotate through the dementia unit, and all the eleven caregivers have completed the required dementia level unit standards. All staff are required to complete competency assessments as part of their orientation and annually. Competencies are completed by staff, which are linked to the annual in-service schedule. Competencies completed include those related to medication management; moving and handling, hand hygiene; first aid and CPR; use of personal protective equipment (PPE); fire and emergency training; and cultural safety. Records reviewed show that all staff have completed the required competencies. The service employs thirteen registered nurses (including clinical manager) and one enrolled nurse. One enrolled nurse and eleven registered nurses are interRAI trained. All registered nurses are encouraged to attend in-service training and complete additional training, including critical thinking; infection prevention and control, including Covid-19 preparedness and identifying and assessing the unwell resident. A record of completion is maintained on an electronic register and staff personnel file.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.	FA	Seven staff files reviewed included evidence of completed orientation, training and competencies and professional qualifications on file where required. There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. A register of practising certificates is maintained

Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.		for all health professionals including (but not limited to) registered nurses, enrolled nurses, general practitioner, pharmacists, podiatrist, physiotherapist, and dietitian. The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation. The service demonstrates that the orientation programmes support registered nurses and caregivers to provide a culturally safe environment to Māori. Staff who have been employed for a year or more have a current performance appraisal on file.
Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	PA Moderate	The registered nurses are responsible for all residents' assessments, care planning, and evaluation of care. Six resident files were reviewed. Two files were reviewed from each level of care: rest home (including on resident under respite contract), hospital and dementia. The initial care plans are developed in partnership with the residents or enduring power of attorney within the required timeframe. Whānau are involved in assessment and care planning, supporting whānau ora and pae ora outcomes. There is documented evidence of resident, enduring power of attorney or family/whānau involvement in care-planning. The care plans are based on data collected during the initial nursing assessments. The individualised long-term care plans are developed with information gathered during the initial assessments and the interRAI assessment (completed for all residents apart from the resident on respite contract). The long-term care plans and interRAI sampled had been completed within three weeks of the residents' admission to the facility. Documented interventions and early warning signs meet the residents' assessed needs. Short term care plans are developed for acute and immediate needs such as infections, wounds, bruises and have been evaluated and signed off once completed or transferred to the long-term care plan. All care plans reviewed had been regularly evaluated to ensure that needs and risks are an ongoing process, and that any changes were documented in the care plan; however, not all implemented interventions are reflected in the care plans developed. Cultural needs, values, and beliefs are identified through assessment and addressed in care plans. Cultural assessments are completed and documented, with access to cultural or spiritual support

		facilitated when requested. The initial medical assessment is undertaken by the general practitioner within the five days following admission and subsequent reviews were undertaken every three months or sooner when their health status changes. The general practitioner interviewed stated that there was good communication with the service, and the registered nurses demonstrated good assessment skills and all referrals to allied health and to specialist service are timely and appropriate. Allied health interventions are documented and integrated into care plans. The service has contracted a physiotherapist for four hours a week. A podiatrist visits six to eight-weekly and a dietitian, speech language therapist, occupational health therapist, continence advisor, hospice specialists, and wound care specialist nurse are available as required. The contact details for family are recorded in the clinical file. Resident records evidenced that family are informed where there is a change in health status. There was evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken where this was required. Wounds included skin tears, lesions, chronic ulcers, abrasions, and pressure injuries There were 2 pressures injuries (stages 2 and 3). There was evidence that if wounds required additional specialist input, this was initiated, and a wound nurse specialist consulted. The caregivers interviewed could describe a verbal and written handover at the beginning of each shift that maintains a continuity of service delivery. The handover observed on the day of audit was found to be comprehensive in nature. Progress notes are written each shift by caregivers and as necessary by the registered nurse and / or by clinical nurse lead. When changes occur with the residents' health, these are reflected in the progress notes to provide an evolving picture of the resident journey. When a resident's condition alters, the registered nurses initiate a review with the GP. There was evidence that registered nurses had added to the progress notes when there was an incident and or change in health status. Caregivers complete monitoring charts including observations; behaviour charts; bowel chart; blood pressure; visual checks, weight; food and fluid; repositioning charts; blood glucose levels; and toileting regime. New behaviours are charted on a behaviour chart to identify new triggers and

		patterns. The behaviour chart entries describe the behaviour and interventions to de-escalate behaviours including re-direction and activities. Monitoring charts have been completed as scheduled. Neurological observations have routinely and comprehensively been completed for unwitnessed falls or where head injury was suspected as part of post falls management. Compliance with observation recordings and monitoring charts is discussed at the two monthly registered nurses' meetings. This is an improvement on from the previous audit, the partial attainment related to HDSS: 2021 #3.2.4 for neurological observation monitoring has been satisfied. Long-term care plans are formally evaluated every six months in conjunction with the interRAI re-assessments and when there is a change in the resident's condition. Evaluations include the degree of achievement towards meeting desired goals and outcomes, are documented by the registered nurses.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	A safe electronic medication management system has been implemented. Twelve electronic medication records were reviewed. The medication management policy identifies all aspects of medicine management in line with relevant legislation and guidelines. Prescribing practices are in line with legislation, protocols, and guidelines. Three-monthly reviews by the GP and allergies were recorded in all electronic medication charts sampled. The service uses pharmacy pre-packaged medicines that are checked by a registered nurse on delivery to the facility. During visual inspection of medication trolleys, it was identified that not all medications sighted were within current use by dates and, not all eyedrops had been dated upon opening. A system is in place for returning expired or unwanted medication to the contracted pharmacy. The medication refrigerator temperatures and medication room temperatures are monitored daily. Medications are stored securely in accordance with requirements. Staff demonstrated a clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures during medication rounds observed. All staff who administer medications have current competencies in place. Registered nurses oversee the use of all pro re nata (PRN)

		medicines and effectiveness is consistently evaluated and documented in the electronic management system. Current medication competencies were evident in staff files. There were no residents self-administering medication on the day of the audit; policy and procedures including assessment, review, and the provision of safe storage were in place where required. Standing orders are not used, and vaccines are not kept on site.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	FA	A nutritional assessment is undertaken by the registered nurse for each resident on admission to identify the residents' dietary requirements and preferences. The nutritional profiles are communicated to the kitchen staff and updated when a resident's dietary needs change. Diets are modified as needed and the cook at interview confirmed awareness of the dietary needs, likes, dislikes and cultural needs of residents. These are accommodated in daily meal planning. Discussion and feedback on the menu and food provided is sought at the residents' meetings and in the annual residents' survey. Residents and a family/whānau member interviewed stated that they are satisfied with the meals provided. The food control plan is current and expires 30 June 2026.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.	FA	There is a documented policy that relates to resident transfer and discharge. Transition, discharge or transfer is managed in a planned and coordinated in a timely and safe manner. Interview with staff confirmed residents and their family/whānau were involved for all discharges to and from the service. Discharge notes are kept on file and discharge instructions are incorporated into the care plan.

Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	FA	There is a current building warrant of fitness certificate in place, which expires on 29 September 2026. There is an annual maintenance plan that includes electrical testing and tagging, residents' equipment checks, call bell checks, calibration of medical equipment and monthly testing of hot water temperatures. The environment is inclusive of people's cultures. The dementia unit is secure with secure and accessible gardens. The corridors have safety rails that promote safe mobility. Corridors are spacious, and residents were observed moving freely around the areas with mobility aids where required. In accordance with the letter from HealthCERT dated July 2024 the service was verified and confirmed suitable to have 64 dual purpose beds. The increase by three (to include the one GP and two respite beds) in the dual-purpose beds has resulted in total bed capacity of 77beds (64 dual-purpose and 13 dementia level care beds). The dual-purpose wings have a mixture of full ensuites, and some have hand basins and shared shower and toilet facilities.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	The service has well documented infection prevention and control programme developed by infection prevention industry experts (Infection Prevention Services [IPS]) . The Board approved the infection prevention and control and anti-microbial stewardship programme that is linked to the quality system. The infection prevention and control programme has been reviewed and reported on annually (last completed January 2025). The infection prevention control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, and the training and education of staff. The infection control programme is linked to the quality system. Infection control is included in the internal audit schedule. Any corrective actions identified have been implemented and signed off as resolved. The infection control programme is reviewed and reported on annually (last completed January 2025). The infection control policy states that Jack Inglis is committed to the ongoing education of staff and residents. Infection prevention and control is

		part of staff orientation and included in the training plan. Staff have completed the required training (February and March 2025). The infection control coordinator, the clinical manager, was attending a regional Health New Zealand infection control study day on the first day of the audit. They also receive additional support from the general practitioner, the laboratory and expertise at Health New Zealand.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	FA	The infection prevention control policy describes surveillance as an integral part of the infection prevention and control programme. Monthly infection data is collected for all infections based on signs, symptoms, and the definition of the infection. Infections are entered into the electronic infection register and surveillance of all infections (including organisms) is collated onto a monthly infection summary. Reports include antibiotic use. This data is monitored and analysed for trends, monthly and annually. Jack Inglis incorporates ethnicity data into surveillance methods and data captured around infections. This is an improvement on from the previous audit, the partial attainment related to HDSS: 2021 #5.4.3 has been satisfied. Infection control surveillance results are discussed at facility meetings. Meeting minutes and data are available for staff. Action plans are completed for any infection rates of concern. Infection control audits have been completed with corrective actions for areas of improvement implemented. Jack Inglis receives regular notifications and alerts from Health New Zealand for any community infections of concern. There have been no outbreaks since last audited. Although there have been no outbreaks, interview with the infection control coordinator demonstrated that there are well documented processes to guide staff in the event of an outbreak, including documentation, debrief and reporting requirements. There were ample supplies of personal protective equipment stored and accessible to staff.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to	FA	The restraint approval process is described in the restraint policy and procedures which meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of restraints.

improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.		The clinical lead is the restraint coordinator and provides support and oversight for restraint management in the facility. The restraint coordinator is conversant with restraint policies and procedures. Interview with the restraint coordinator described the organisation's commitment to restraint elimination and implementation across the organisation. The reporting process to the board includes restraint data that is gathered and analysed monthly. On the day of the audit there were no residents utilising restraints. Interviews with staff confirmed who are actively involved in the ongoing process of restraint elimination. Training for all staff occurs at orientation and annually. This includes a competency assessment.

Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our 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 2.2.5 Service providers shall follow the National Adverse Event Reporting Policy for internal and external reporting (where required) to reduce preventable harm by supporting systems learnings.	PA Low	The service has well documented policies and procedures related to incident management and essential reporting requirements. At the time of the audit, interview with the clinical manager demonstrated their awareness of the reporting requirements including how to access the guidelines. Since previous audit there have been section 31 and SAC reports related to change in clinical manager, sudden death, fall related fractures. However, two power outage events that occurred in July and August were not reported as per section 31 reporting requirements. Review of the quality documents and meeting minutes showed that there were planning processes implemented, regular checks completed for the residents and	There is no documented evidence of section 31 reports completed for two power outages.	Ensure compliance with reporting requirements 90 days

		debrief meetings held to identify what went well and areas of improvement in case of future events. The records reviewed indicate that the outages were managed well and no adverse events occurred in relation to the outages.		
Criterion 3.2.3 Fundamental to the development of a care or support plan shall be that: (a) Informed choice is an underpinning principle; (b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan; (c) Comprehensive assessment includes consideration of people's lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia; (f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated;	PA Moderate	The service has comprehensive policies in place to guide assessment, support planning, and care evaluation. Registered nurses and enrolled nurses are responsible for completing assessments, and developing resident-centred care interventions. The care delivery observed and described in progress notes was consistent with assessed needs; however, three out of six reviewed resident files identified that long-term care plans did not consistently document all interventions being implemented to address assessed needs. management strategies.	i).The care plan for a resident with a pressure injury did not fully document all interventions implemented to manage the condition. ii).The care plan for a resident with diabetes mellitus did not include sufficient detail to guide ongoing management of blood glucose monitoring device and signs and symptoms of hyperglycaemia and hypoglycaemia. iii).The care plan for a resident with arthritic shoulder pain did not include documented non-pharmacological pain management interventions.	i).-iii).Ensure that all interventions implemented in response to the resident's assessed needs are clearly and consistently documented in the care plan. 60 days

(g) Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention; (h) People's care or support plan identifies wider service integration as required.				
Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.	PA Moderate	Policies and procedures are in place to guide medicines management and are aligned with relevant legislation and guidelines. An electronic medication management system is used. Medication room temperatures are monitored, and stored medications are subject to routine checks. Processes exist for the disposal of expired medications and for labelling and expiry control; however, these are not always consistently applied in practice.	i).Four eye drop medications in use were not labelled with opening dates. ii).Two midazolam nasal sprays were not discarded after their manufacturer's use-by dates.	i).– ii).Ensure all medications in use are appropriately labelled with opening dates and discarded in accordance with manufacturer expiry requirements. 90 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

No data to display

End of the report.