

Dutch Village Trust - Ons Dorp Care Centre

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 Audit (NZ) 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:	Dutch Village Trust
Premises audited:	Ons Dorp Care Centre
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 26 September 2017 End date: 27 September 2017
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:	41

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

Ons Dorp provides rest home and hospital level care for up to 45 residents. The service is operated by Dutch Village Trust and managed by general manager and a clinical manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service`s contract with the district health board. The audit process included review of policies and procedures, review of resident` records and staff records, observations and interviews with residents, family, management, staff contracted allied health professionals and a general practitioner.

The audit has resulted in no areas of improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff have knowledge and understanding of the rights of residents and consumer rights legislation. Services are provided in a manner that includes residents' rights. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Residents who identify as Māori have their needs met. The individual values and beliefs of residents are documented and respected by staff. Staff communicate effectively with residents and their families and friends. Open disclosure is practiced and consent is sought verbally and in writing from residents where appropriate. Residents have access to advocacy services and information on advocacy services is available to residents and relatives. Staff encourage residents to maintain links with their family/whanau and community.

The clinical manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively. There is one health and disability complaints which still remains open since 25 July 2016.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Dutch Village Trust is the governing body and is responsible for the service provided at this facility. A business and quality and risk management plans are documented and includes the scope, direction, goals and values of the organisation. Systems are in place for monitoring the services provided, including regular monthly reporting by the clinical manager to the general manager who reports to the trust board.

The facility is managed by the general manager who is supported by the clinical manager. A quality and risk management system is in place which includes and internal audit activity programme, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported at the quality and staff meetings, with discussion of trends and follow up where necessary. Meeting

minutes, graphs of clinical indicators are accessible for staff. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and the hazard register is up to date.

A suite of policies and procedures cover the necessary areas, are current and reviewed regularly.

The human resource management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation and staff training programme ensures staff are competent to undertake their role. A systematic approach to identify, plan and facilitate and record training supports safe service delivery, and includes regular individual performance review.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. After hours is covered adequately by senior staff.

Residents` information is accurately recorded, securely stored and is not accessible to unauthorised people. Up to date, legible and relevant residents` are maintained in using an integrated record.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The care plans are developed by registered nurses with input from the residents, staff and family member representatives. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the resident and contractual requirements.

Planned activities are appropriate to the residents assessed needs and abilities. Residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management system in place and medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner (GP) according to policy. There is one resident self-administering medicines and there are systems in place to ensure compliance and the resident is assessed as competent.

The kitchen is managed by an independent catering service. Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility has been purpose built. The rooms are individual some with en-suites bathrooms but most bathroom facilities are in close proximity to the resident's rooms. There are three double rooms. Two are in use with one resident in each room. All rooms are of adequate size to provided personal care.

All building and plant complies with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented.

Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas with seating are available.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite, with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and a sprinkler system and call points installed in case of fire. Access to emergency lighting and water is available and a generator can be arranged. Residents report a

timely staff response to call bells. A contracted security company monitors the facility each night and other security measures by staff are well maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Thirteen enablers are in use and no restraints at the time of the audit. Restraint is only used as a last resort when all other options have been explored. An assessment, approval and monitoring process with regular reviews occurs. Enabler use is voluntary for the safety of residents in response to individual requests. Staff receive training at orientation and thereafter every two years, including all required aspects of restraint enabler use, alternatives to restraint and dealing with difficult behaviours. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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.
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Infection control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff. Documentation

evidenced that relevant infection control education is provided to staff. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infection is carried out as specified in the infection control programme.

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	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the annual in-service training programme. Residents' rights are upheld by staff thus include, staff knocking on residents' doors prior to entering their rooms, speaking to residents with respect and dignity and calling residents by their preferred names. Staff on the audit days demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents interviewed reported that they are treated with respect and understand their rights. The family/whānau reported that residents are treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give</p>	FA	<p>There is an informed consent policy in place. Consent is included in the admission agreement and sought for appropriate events. Staff use verbal consents as part of daily service delivery. Staff interviewed demonstrate an understanding of informed consent processes. Residents and family/whānau confirmed that consent issues are discussed with them on admission and appropriate forms are shown to them at this time and thereafter as relevant. All residents' files reviewed included written consent.</p> <p>All residents have the choice to make an advance directive and appropriate documentation is held in the resident's record.</p>

informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service, with the advocate visiting the service to provide information to residents/families and staff. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Residents and family/whanau were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents have access to visitors of their choice at any time of the day. They are supported to access services within the community if they are able to do so and to maintain their links with family and friends. Visitors were seen to be welcomed by staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is a complaints information and forms available in a number of areas in the facility.</p> <p>The complaints register showed that five complaints have been received over the past year and that actions taken, through an agreed resolution, are documented and completed within the timeframes specified in the Code. Action plans show any required follow up and improvements have been made where possible. There is currently one Health and Disability Commissioner (HDC) complaints that has remained opened since 25 July 2016. All records were reviewed and a copy of the initial HDC complaint letter and all responses from both parties are recorded. All information is accessible to the clinical manager and is maintained in a confidential and professional manner</p> <p>The clinical manager is responsible for complaints management and follow up. All staff confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and families receive an information pack on admission that includes: the Code; their rights and responsibilities; informed consent; cultural and language support; how to make a complaint; and how to access advocacy services. The pamphlets have been translated into Dutch and Chinese as per resident need. The Code and the complaints process are displayed in communal areas. The admitting registered nurse explains their rights to new residents. Residents interviewed confirmed they have access to an</p>

		<p>independent advocate, if needed.</p> <p>The signed residents' agreements were sighted in all records reviewed and meet the requirements of this standard and district health board requirements.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There are documented policies and procedures in place to ensure residents are treated with respect and dignity. Residents and family/whanau confirmed that they receive services in a way that respect their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. Residents are referred to by their preferred name as observed on the audit days. There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.</p> <p>Care plans reviewed included documentation relating to the resident's abilities with strategies to maximise independence. The records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Residents receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values and beliefs. Staff indicated that they support residents who identify as Māori to integrate the cultural values and beliefs that they choose if admitted. There were no Maori residents during the audit days. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on Tikanga best practice is available and access to Māori support and advocacy services are available if required. Staff demonstrated knowledge of the individual needs of the residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs. Church services and spiritual support is available as the resident desires. Residents and family/whanau interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are being met. Staff interviewed confirmed an understanding of cultural safety in relation to care.</p>
<p>Standard 1.1.7: Discrimination</p>	FA	<p>The employment job description and the Code of Rights define residents' rights relating to discrimination.</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>Staff interviewed verbalise they would report any inappropriate behaviour to the manager, clinical manager or registered nurse (RN). The manager reported management would take formal action as part of the disciplinary procedure if there was an employee in breach of conduct. There was no evidence of any behaviour that required reporting and interviews with residents and family/whānau indicated no concerns.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals respectively. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. There is specific training and education to assist staff in managing residents with cognitive impairment or behaviours of concern. The activities programme evidences good practice for residents in the rest home and hospital.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy and associated procedure is in place to ensure staff maintain open communication with residents and their families. Communication with family members is documented in residents' records. Incident forms record evidence of communication with the family following adverse events. The management is aware of situations that require notification to external agencies. Residents interviewed confirmed that staff communicate well with them. Interpreting services are contacted if required to ensure that communications are understood.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The Dutch Village Business Plan 2016 – 2018 and the quality and risk management plan 2017 – 2019 were made available and both are reviewed annually and include the purpose, values, scope, direction and objectives of the organisation. The documents describes the annual and longer term objectives and the associated operational plans. The clinical manager provides monthly reports to the general manager in regard to infections, staffing issues if any, quality and risk management, quality improvements, internal audits, complaints and other aspects of the day to day management of the facility. The general manager provides a monthly report to the Dutch Village Trust Board. Meeting minutes evidence adequate information to monitor performance is reported. The general manager is responsible for reporting financial performance, emerging risks and issues.</p> <p>The rest home is managed by a general manager who holds relevant business qualifications and is supported by the clinical manager who has relevant health professional qualifications and has been in the</p>

		<p>role for over two years. The clinical manager is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a job description and individual employment agreement. The clinical manager confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through attending relevant education and training related to aged care and management. The clinical nurse is supported by a charge nurse. The quality team meet monthly with the general manager.</p> <p>The service hold contracts with the DHB for rest home and hospital level care. On the day of the audit there are 19 hospital and 21 rest home residents.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the general manager is absent, the clinical manager carries out all required duties under the delegated authority. A charge nurse is available to cover the clinical manager if on annual leave or study leave. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a quality and risk system that reflects the principles of continuous improvement and is understood by staff. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents and any infections.</p> <p>Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs and related information reported and discussed at the management team meeting/quality and risk team meetings and staff meetings. Minutes reviewed include discussion on pressure injuries, restraints, falls, complaints, incidents/events, infections, audit results and activities. Any corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvement is occurring. Resident and family surveys are completed annually. Policies reviewed cover all necessary aspects of the service and contractual requirements and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff are updated on new policies or changes to policies through the staff meetings.</p> <p>The general manager described the processes for the identification and monitoring of risks and development of any mitigation strategies. The risk register shows consistent review and updating of any</p>

		risks, risk plans and the addition of new risks. The general manager and clinical manager are well informed of responsibilities of health and safety. The clinical manager has attended training in the Health and Safety at Work Act (2015) requirements.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed-up in a timely manner. Adverse event data is collated, analysed and reported to the quality improvement meetings and meeting minutes reviewed show discussion in relation to any trends, action plans and improvement made.</p> <p>Policy and procedures described essential notification reporting requirements. A section 31 was reported in relation to vaccinations inappropriately being stored on site. There is no evidence of any being stored on the day of the audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained. Check lists are in the front of all staff records reviewed.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from a `buddy` through their initial orientation period. A sample of staff records reviewed show documentation of completed orientation and a performance review annually is completed.</p> <p>Continuing education is planned on a two year basis. Mandatory training requirements are defined and scheduled to occur over the course of the year. Care staff have wither completed or commenced a New Zealand qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The service has three careerforce trained assessors on site. Five permanent staff (HCAs) have not completed career force training but have completed some of the ACE programme used previously. One casual health care assistant is yet to complete any training. Fourteen (HCAs) have level 4, 12 have level three and three have level 2. Records are maintained by the clinical manager. Staff reported that the annual performance appraisal process provides an opportunity to discuss individual training needs. Medication competencies are completed are completed annually for all staff who administer medications. Appraisals are current for all staff.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of residents, supported by the use of a workload measurement tool. The minimum number of staff is provided during the night shift and consists of one registered nurse and three healthcare assistants. There is always a registered nurse on call. The clinical manager can be called at any time after hours and weekends. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and review of a four months of four week roster cycles sample during the audit confirmed adequate staff cover has been provided. The organisation contracts to a bureau for short notice roster gaps if needed. At least one staff on duty has a current first aid certificate and there is 24 hours/seven days a week registered nurse cover for this home.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all resident's information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' records sampled for review. Clinical notes were current and integrated with GP and allied health provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable. Residents' records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The entry to service policy includes all the required aspects on the management of enquiries and entry. Ons Dorp Care Centre welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies.</p> <p>Records reviewed confirmed that admission requirements are conducted within the required time frames and signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Relatives and residents interviewed confirmed that they received sufficient information regarding the services to be provided.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident's records to confirm this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There is a documented policy in the management of the medication system. All medication entries sampled on the electronic system complied with legislation, protocols and guidelines. The e-prescribing electronic system is accessed by use of individual passwords and generic facility log in. Allergies are documented, identification photos are uploaded and three-monthly reviews are completed. The RN and caregiver were observed administering medication correctly in their respective departments. Medication reconciliation is conducted by the RNs when a resident is transferred back to service.</p> <p>The service uses pharmacy pre-packed packs that are checked by the RNs on delivery. The controlled drug register is current and correct. Weekly, monthly and six monthly stock takes are conducted and all medications are stored appropriately. There was one resident self-administering medication at the time of the audit and was assessed as competent. There is a policy and procedure for self-administration of medication if required. An annual medication competency is completed for all staff administering medications and medication training records were sighted. The medicines management system complies with legislation, protocols and guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Meal services are prepared on site by a contractor and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. The residents have a kitchen dietary profile developed on admission which identifies dietary requirements, likes and dislikes. The resident's weight is monitored regularly and supplements are provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring on food, fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. The residents and family/whanau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The RN reported that all consumers who are declined entry are recorded on the pre-enquiry form and when a resident is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The initial assessments are completed within the required time frame on admission while care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews residents and relatives expressed satisfaction with the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans are resident centred, integrated and provide continuity of service delivery. The assessed information is used to generate resident's lifestyle care plans and short term care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled are integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The documented interventions in resident short term care plans and lifestyle care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed also by the GP in the interview conducted. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies are observed and the staff confirmed they have access to the supplies and products they needed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the</p>	FA	<p>The planned activities are meaningful to the residents. The activities programme covers physical, social, recreational, emotional and cultural needs of the residents. The activities coordinator reported that they modify activities based on the resident's response and interests and also according to the capability and cognitive abilities of the residents. The rest home and hospital residents have the same activity</p>

<p>service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>programme with an option of one on one sessions provided for the hospital residents if needed.</p> <p>The residents were observed to be participating in meaningful activities on the audit days. Residents were observed to be going offsite with family/friends and there are community organisations providing activities at the service. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident's lifestyle care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Relatives and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Resident short term care plans are developed when needed and signed and closed out when the short term problem has resolved.</p>
<p>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.</p>	FA	<p>There is a documented process for the management of all referrals. The service utilise a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GP.</p>
<p>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.</p>	FA	<p>Documented processes for the management of waste and hazardous substances were in place. Infection control documentation includes a waste management section detailing procedures for waste (blood and bodily fluids) management and disposal.</p> <p>The doors to the areas storing chemical were secured and containers labelled. Appropriate signage is displayed where necessary. There is a designated chemical handler who has completed the required chemical training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Any related incidents are reported in a timely manner.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this</p>

		including aprons, hats and gloves.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness expires 23 November 2017 and is publically displayed. Appropriate systems are in place to ensure the residents` physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personal and observation of the environment.</p> <p>Eternal areas are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe. Residents interviewed confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and they are pleased with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is a mix of toilet, showers and bathing facilities. This includes rooms with ensuites, and separate showers and toilets. There are adequate numbers of accessible bathrooms and toilets throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories ae available to promote resident independence. There is a separate visitor`s toilet, staff toilets and a designated staff room. There is one designated disability toilet with a raised toilet seat available as needed.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their own rooms safely. All bedrooms provide single accommodation except for three shared rooms. Two of the three are occupied with only one resident in each room. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids walking frames and wheel chairs. Staff and residents reported the adequacy of bedrooms. Mobility scooters are stored in a designated area and do not impede walkways or create a hazard for mobile residents.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining room and lounge areas are spacious and enable easy access for residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and resident needs. It is arranged in a manner which enables residents to mobilise freely. The main dining area is in the main lounge and a smaller dining room is in the hospital wing.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The laundry facilitator has been employed in the role for two and a half years and is the sole service provider for this area of service delivery. All laundry is undertaken on site. Resident's personal items are laundered on site or by family members if requested. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry is currently washed by the laundry staff member interviewed who demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen.</p> <p>A contracted company provides education, checks equipment, chemical supplies and the pump system directly feeds into the equipment provided which includes a large commercial washing machine, one large commercial dryer and one small washing machine for personal clothing eg woollens are done separately as explained by the laundry staff member.</p> <p>The laundry facilitator is fully trained to work in the laundry and has level 2 currently. This was confirmed in the staff training records reviewed. Chemical training has been provided. Chemicals are stored in a lockable cupboard and were in appropriately labelled bottles. Cleaning and laundry processes are monitored through the internal audit programme. A separate staff member is performing the cleaning duties throughout the facility.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and procedures for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct and directs the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service dated 18 March 2010. A trial evacuation takes place six monthly with a copy sent to the New Zealand Fire Service and the contracted company who provides all the equipment checks. The last fire evacuation was dated 16 August 2017. The staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p>

		<p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and a gas barbecue were sighted and meet the requirements for the 41 residents. Water storage tanks are located around the complex, and there is emergency lighting on site which is regularly tested. There is no generator on-site but access to one is arranged if required.</p> <p>Call bells alert staff to residents requiring assistance. Call systems audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Door and windows are locked automatically at a predetermined time and a security company checks the premises at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents` rooms and communal areas have opening external windows. Many have doors that open onto the outside garden or small patio areas. Electric heating provided is provided with underfloor, heat pumps (2) in the main lounge and wall heaters in all rooms and bathrooms with additional heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facility is maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Ons Dorp Care Centre provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The RN is the infection control coordinator (ICC) and has access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place.</p> <p>The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</p>
<p>Standard 3.2: Implementing the</p>	FA	<p>The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control</p>

<p>infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and could locate policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included: GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control</p>	<p>FA</p>	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.</p>

programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisations policies and, procedures and practice guidelines inclusive of role and responsibilities.</p> <p>On the day of the audit, 13 residents were using an enabler and no residents were using a restraint. Enablers were the least restrictive and were used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. This provides for a robust process which ensures the on-going safety and wellbeing of the resident.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes and records reviewed of those residents who have enablers and from interview with staff. The use of the enabler is discussed at the care evaluations six monthly as well for each resident.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, there 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.