

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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Dutch Village Trust
Premises audited:	Ons Dorp Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 February 2022 End date: 11 February 2022
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:	39

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
Yellow	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
Red	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 is governed by a trust board and managed by a general manager and a clinical manager.

Ons Dorp care centre provides hospital (including medical) and rest home care for up to 45 residents, all beds are dual purpose (rest home and hospital). On the day of audit there were 39 residents.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, relatives, staff, management, and general practitioner.

The service has a current strategic plan, a business plan, and a quality plan/ risk plan. Quality is monitored through the service meetings and reports to the trust board.

The clinical manager is a registered nurse and has been in the role for three years and employed at Ons Dorp for four years. She is supported by an experienced general manager and a team of registered nurses.

There are well-developed systems, processes, policies, and procedures that are structured to provide appropriate quality care for people who use the service.

This audit identified two areas requiring improvement around neurological observations and communication of quality outcomes. The service has been awarded one continuous improvement around good practice.

Consumer rights

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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The service complies with the Health and Disability Commissioner’s Code of Health and Disability Consumers’ Rights. Staff strive to ensure that care is provided that focuses on the individual resident, values residents' autonomy and maintains their privacy and choice. Cultural needs of residents are met. Policies are implemented to support residents’ rights, communication, and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The clinical manager is supported by registered nurses, Health care assistants and support staff. The quality and risk management programme includes a service philosophy, and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Resident and family meetings are held. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated. A comprehensive education and training programme is implemented with a current plan in place. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate staff cover for the effective delivery of care and support.

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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Access to services are appropriate and efficiently managed by suitably qualified staff using relevant information provided.

The multidisciplinary team, including registered nurses and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

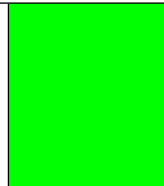
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

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.

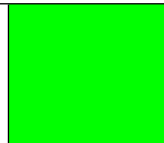


Standards applicable to this service fully attained.

The facility is appropriate to the needs of residents and is clean and well maintained. Appropriate policies and procedures are available along with product safety charts. Chemicals are stored safely throughout the facility's storage areas. There is a current building warrant of fitness in place. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. All areas are accessible to people with a disability. External areas are safe and well maintained. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies are provided. There is an approved fire evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there was one resident using restraint and one resident with an enabler.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. There are Covid-19 alert level management plans in place and sufficient PPE is on hand. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted-upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	47	0	2	0	0	0
Criteria	1	98	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) policy and procedure is implemented. Discussions with the general manager, clinical manager and 17 staff (seven health care assistants (HCAs) who cover morning and afternoon shifts, three registered nurses (RN), one activities person, one chef, one kitchen hand, one laundry person, a housekeeper, physiotherapist, and maintenance person) confirmed their familiarity with the Code. Interviews with four rest home level residents, two hospital level residents and four relatives (hospital level) confirmed that the services being provided are in line with the Code. Staff receive training on the Code, last occurring in August 2021.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission and sighted all resident files reviewed Advance directives for continuing care (where appropriate) were completed and on the resident files. Resuscitation plans were sighted in all files and were signed appropriately. Copies of enduring power of attorney (EPOA) were present in resident files. Systems are in place to ensure residents and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The HCAs and registered</p>

		<p>nurses interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>All long-term resident's files sampled had signed admission agreements on file.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>There is a policy that describes the role of advocacy services. Staff receive annual training on advocacy. Information about accessing advocacy services is available in the information presented to residents and their families during entry to the service. Advocacy support is available if requested. Interviews with staff, residents and relatives confirmed that they were aware of advocacy services and how to access an advocate. The complaints process reminds the complainant of their right to contact the Health and Disability Advocacy Service with contact details provided.</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 and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, (e.g., attending cafés and restaurants) as covid restrictions allow. Interviews with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</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 describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register. There were seven recorded complaints for 2020. including one health and disability complaint and one through the DHB. All complaints have been investigated and resolved. There are four complaints 2022 YTD. Complaints have been investigated, including a complaint regarding resident room changes and lounges.</p> <p>Notification regarding a complaint was communicated to the auditors dated 10 February 2021. This audit noted that communal areas (including in the refurbished wing) were spacious and included easily accessible outside areas. service provision requirements were well</p>

		<p>documented and timely, including resident assessments (link 1.2.4.2). The quality and risk system is well documented, however resident surveys and internal audit out comes were not well reported (link 1.2.3.6).</p> <p>Complaints are linked to the quality and risk management system. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters displaying the Code in English and in Māori. The service is able to provide information in different languages and/or in large print if requested. On entry to the service, the clinical manager or registered nurse discuss the Code with the resident and the family/whānau. An information pack is given to the resident, next of kin or enduring power of attorney (EPOA) to read and discuss. Residents and relatives interviewed identified they are well informed about the Code of Rights. Six weekly care centre meetings and regular care centre committee meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed (link 1.2.3.6)</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>Ons Dorp Care Centre has policies which align with requirements of the Privacy Act and Health Information Privacy Code, policies are form a consultant and personalised to Ons Dorp. During the audit, staff demonstrated gaining permission prior to entering residents' rooms. All care staff interviewed demonstrated an understanding of privacy and could describe how choice is incorporated into residents' care. Residents and family members interviewed confirmed that staff promote the residents' independence wherever possible, and that residents' choices are encouraged. There is an abuse and neglect policy that is implemented. Staff education and training on abuse and neglect has been provided as part of the training programme.</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</p>	FA	<p>The service has established Māori cultural policies. The policies provide recognition of Māori values and beliefs and identify culturally safe practices for Māori.</p> <p>Best practice policies and procedures are available to staff and specialist advice is sought, when necessary. The service has one resident who identifies as Māori. This resident was interviewed and expressed satisfaction with the service. A cultural assessment was completed on entry to the service and cultural care was documented into the care plan.</p>

beliefs.		
<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>The service has established cultural policies aimed at helping to meet the cultural needs of its residents. A high number of the residents are Dutch and so staff training includes staff learning many Dutch words and phrases. Residents interviewed all appreciated the staff efforts to learn their language.</p> <p>All residents and relatives interviewed reported that they were satisfied that the residents' cultural and individual values were being met. Information gathered during assessment, including residents' cultural beliefs and values, is used to develop a care plan. The resident (if appropriate) and/or their family/whānau are asked to consult on the care plan. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. All of the residents were able to speak and understand English.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. Professional boundaries are reconfirmed through education and training sessions, at handover meetings, and performance management if there is infringement with the person concerned. Interviews with all staff confirmed an awareness of professional boundaries including the boundaries of the care workers' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>Promoting and encouraging good practice was evident during the audit. Registered nursing staff are available on call after hours and weekends. The service receives support from the district health board including visits from specialists (e.g. wound care, mental health) as well as staff education and training. Physiotherapy services are provided weekly.</p> <p>Ons Dorp has worked with the DHB to reduce the incidence of falls and bruises for residents. The incidence of fall and bruises had fallen and continues to decrease, the service has exceeded the standard in this area.</p> <p>The service has developed a palliative care service. The palliative pathway activation (PPA) process was commenced in association with West Auckland palliative service. The clinical manager has trained as a palliative link nurse and all RNs have undertaken palliative care training. The service informs that early identification of residents on the palliative journey enables them to work with the resident, family, and specialist palliative service for effective care at end of life. There is an implemented process where the palliative pharmacist reviews medications and links to the GP for prescribing.</p>

		<p>There is a robust education and training programme for staff that includes in-service training, impromptu training, and competency assessments. Podiatry services and hairdressing services are provided. The service has links with the local community and encourages residents to remain independent.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. A record of family communication is indicated by a specific progress note in each resident's file.</p> <p>Twelve incidents/accidents forms selected for review indicated that family were informed. Families interviewed confirmed they are notified of any changes in their family member's health status.</p> <p>Interpreter services are available if needed. Staff and family are utilised in the first instance and staff are learning some Dutch words and phrases.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Ons Dorp is governed by a trust board and managed by a general manager with the support of the clinical manager. The trust board consists of seven members including a doctor, a lawyer, and a businessperson. Four of the trust members are elected. The board receives a comprehensive monthly care centre report from the clinical manager report including all aspects of care, quality, and risk around the care centre. An overall report of the village including a financial report is provided from the general manager.</p> <p>Ons Dorp care centre provides hospital (geriatric and medical) and rest home care for up to 45 residents. All beds are dual purpose (rest home and hospital). On the day of audit there were 39 residents; 21 hospital level and 18 rest home level residents, including one hospital level resident funded through the long-term support- chronic conditions contract (LTS-CHC) with the district health board (DHB), the remainder residents were funded through the Age-Related Residential Care Agreement (ARRC).</p> <p>The service has a current strategic plan, a business plan, and a quality plan/ risk plan in place for 2019- 2022. Quality is monitored through the service meetings and reports to the trust board. There are specific health and safety objectives which are monitored through the health and safety/quality meetings.</p> <p>The clinical manager is a registered nurse, and has been in the role for three years, and</p>

		<p>employed at Ons Dorp for four years. She is supported by an experienced general manager and a team of registered nurses. The clinical manager reported that she is very well supported by the clinical specialists at the DHB. The nurse manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility.</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>In the absence of the clinical manager, the senior registered nurse supported by the GM and the admin manager take on the role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>A quality and risk management programme is in place and embedded in practice. Interviews with the managers and staff confirmed their understanding of the quality and risk management systems.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>Data collected (e.g. falls, medication errors, wounds, skin tears, pressure injuries, complaints, challenging behaviours) are collated and analysed with results communicated to staff. Corrective actions are implemented and followed up.</p> <p>An internal audit programme is in place. Areas of non-compliance include the initiation of a corrective action plan with sign-off by a manager when implemented but are not well evidenced as communicated to staff via meetings.</p> <p>Quality and risk data (other than audits) is shared with staff via meetings and posting results in the staff room. Minutes of these meetings are made available to all staff. Required actions and resolutions from facility meetings are documented. Resident/relative meetings are monthly.</p> <p>Annual resident/relative satisfaction surveys are completed, however the most recent (2021) was not collated and reported to respondents.</p> <p>There is a strong health and safety commitment, and health and safety is reported to the</p>

		<p>quality meeting. There are designated health and safety representatives all of whom have completed health and safety training.</p> <p>Falls prevention strategies are in place including intentional rounding, sensors, post falls reviews, physiotherapy reviews and individual interventions. The clinical manager and RNs review all falls and document a monthly report. Health care worker interviews confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>There is an accident and incident reporting policy. Adverse events are investigated by the clinical manager and/or registered nurse, as evidenced in all twelve accident/incident forms reviewed. Adverse events are trended and analysed with results communicated to staff. There is evidence to support actions are undertaken to minimise the number of incidents. Clinical follow-up of residents is conducted by a registered nurse. Unwitnessed falls include neurological observations, but these are not consistently recorded according to policy.</p> <p>Discussion with the facility manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. Examples provided included: A section 31 for RN shortage, one stage three pressure Injury (now resolved), and a resident who resident was absent without leave, police were informed twice. There have been no infection control outbreaks</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place which include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience, and veracity. A register of current practising certificates is maintained. Seven staff files reviewed (three HCAs, two RNs, one maintenance person and one activities person) reflected evidence of: reference checking, signed employment contracts, signed job descriptions, and completed orientation programmes.</p> <p>There is an orientation programme that provides new staff with relevant information for safe work practice including safe resident handling, health and safety, and fire safety. Staff orientations were fully completed. Performance appraisals are completed annually. There is an implemented annual education and training plan that exceeds eight hours annually per staff member. Training is primarily held at monthly sessions and on an individual basis with competency assessments linked to training. A register for each training session and an individual staff member record of training was verified. All new staff are booked for Hospice</p>

		<p>training via zoom and longer service staff are also booked for refreshers.</p> <p>Registered nurses are supported to maintain their professional competency. The clinical manager and two RNs have completed their interRAI training with two further RNs booked for training. The RNs are all enrolled in online training linked to the DHB and competencies include male catheterisation, end of life care wound care and syringe driver</p> <p>The service encourages Careerforce qualifications for staff. There are 15 HCAs with level four Careerforce qualification, two with level three and five with level two. Of the four-activity staff- two are level four and two level three.</p> <p>The cook has completed a qualification in food safety and food hygiene. All kitchen staff have completed their food safety training on site. Chemical safety training is included in staff orientation and as a regular in-service topic.</p> <p>Current registered nursing staff and external health professionals (general practitioners, physiotherapist, pharmacists, podiatrist) practising certificates were sighted.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A staff rationale and skill mix policy is in place. There is a roster in place that ensures that there are sufficient staff rostered on. The fulltime clinical manager is a registered nurse. The clinical manager with support from registered nurses provide on-call cover afterhours and at weekends.</p> <p>There is one roster and staff are allocated residents on a daily basis. On the day of audit there were 21 hospital level residents and 18 rest home.</p> <p>There is generally two RNs on the morning shift, one to two on the afternoon shift, and one on nights.</p> <p>On morning shift, there are seven full shift HCAs, afternoon shift, there are five full shift HCAs and at night, there are two HCAs.</p> <p>Staff were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that the staffing levels are satisfactory and that the RN and clinical manager provide good support. Residents and family members interviewed reported there are sufficient staff numbers.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual electronic record. Residents' files are protected from unauthorised access. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Individual resident files demonstrated service integration. This included medical care interventions and records of the activity's coordinator. Medication charts are stored electronically and protected from unauthorised access.</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 service's admission policy for the management of inquiries and entry is in place. Ons Dorp's admission pack sighted contained all the information about access and entry to the service. Assessments and entry screening processes are documented and communicated to the family/whānau of choice, where appropriate, local communities, and referral agencies. Files sampled evidenced that completed Needs Assessment and Service Coordination (NASC) service authorisation forms were completed before entry. Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. The family/whānau and residents interviewed confirmed that they received sufficient information regarding the services 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>	FA	<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.</p> <p>Residents and their families are involved in all exits or discharges to and from the service and there was sufficient evidence in the residents' 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>	FA	<p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation.</p> <p>Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from the hospital or any external appointments. The RNs check medicines against the prescription, and these were updated every fortnight or when there are any medication</p>

		<p>changes. Medication competencies were completed annually for the registered nurses and senior care staff administering medication. Annual training is provided & where there are medications errors by staff.</p> <p>There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. Eye drops are dated on opening, there were no expired drugs on site. Monitoring of medicine fridge and medication room temperatures is conducted regularly and deviations from normal were reported and attended to promptly. Records were sighted. The RN was observed administering medications safely and correctly. Medications were stored safely and securely in the trolley and locked treatment room. There were two rest home level residents self-administering inhalers and were assessed as competent. Competencies are checked and signed off by the GP three monthly. Medications were stored securely (sighted) in resident rooms.</p> <p>Fourteen electronic medication charts were reviewed. All had photo identification, allergies, and three-monthly reviews by the GP. 'As required' (PRN) medications were appropriately prescribed with indications for use documented. As required medications had been appropriately administered with efficacy documented on the electronic medication system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The kitchen service is outsourced, and it complies with current food safety legislation and guidelines. The food service is managed by the chef assisted by a kitchen hand. There is an approved food control plan for the service which expires on 1 January 2023. Meal services are prepared on-site and served in the respective dining areas. The menu was reviewed by the registered dietitian in November 2020. The kitchen staff have current food handling certificates.</p> <p>Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. All alternatives are catered for. The residents' weights are monitored regularly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents throughout the day and night when required.</p> <p>The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. Labels and dates were on all containers. Thermometer calibrations were completed every three months. Records of temperature monitoring of food, fridges, and freezers are maintained.</p> <p>The residents and family/whānau interviewed indicated satisfaction with the food service. All</p>

		decanted food had records of use by dates recorded on the containers and no expired items were sighted.
<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	The clinical manager reported that all potential residents who are declined entry are recorded. When an entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer/family is referred to the referral agency to ensure the person will be admitted to the appropriate service provider.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Residents have their level of care identified through the needs assessment by the NASC agency. Initial assessments were completed within the required time frame on admission, while residents' care plans and interRAI are completed within three weeks, according to policy. Assessments and care plans are detailed and included input from the family/whānau, residents, and other health team members as appropriate. Additional assessments were completed according to the need (e.g., behavioural, nutritional, continence, and skin and pressure risk assessments). The nursing team utilises standardised risk assessment tools on admission. In interviews conducted, family/whānau and residents expressed satisfaction with the assessment process.
<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>The assessment findings and input from the resident and/or family/whānau inform the care plan and assist in identifying the required support to meet residents' goals and desired outcomes. Plans sampled were resident-focused and stated actual or potential problem/deficits, set goals for meeting these, and detailed required interventions. Short-term care plans were used for short-term needs, and these were reviewed weekly or as required. There was documented evidence sighted in samples of short-term care plans reviewed.</p> <p>The review process determined the effectiveness of the interventions in ensuring the resident is achieving set goals. The care plans are amended, as necessary, to ensure the interventions and goals are appropriate, congruent, and achievable.</p> <p>The RN reported that behaviour management plans were implemented as required especially to residents presenting with any behavioural issues of concern. Family/whānau and residents confirmed they were involved in the care planning process.</p>

		Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as gerontology nurses, physiotherapists, district nurses, dietitians, and GP.
<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>All seven residents' files sampled evidenced that care plans developed had interventions that were relevant and adequate to address the identified needs of residents. When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to): accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident file.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds and skin tears. There were no pressure injuries on the day of audit. There was a range of equipment readily available to minimise pressure injury.</p> <p>A range of equipment and resources are available, suited to the level of care provided and following the residents' needs. Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences.</p> <p>Short-term care plans document appropriate interventions to manage short term changes in health.</p> <p>Monitoring occurs for weight, vital signs, blood glucose, pain, challenging behaviour, wounds, restraint, and continence. Registered nurses review the monitoring charts and report identified concerns to the GP, nurse practitioner or nurse specialist.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the</p>	FA	<p>Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by an activities coordinator assisted by three activities assistants. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays are celebrated. The chaplain, hairdresser, and physiotherapist are on-site weekly.</p>

<p>service.</p>		<p>Resident life history and leisure is completed for each resident within two weeks of admission in consultation with the family. Residents' activities care plans were evaluated at least six monthly.</p> <p>The activity programme is formulated by the activities staff. The activities are varied and appropriate for people assessed as requiring rest home, hospital level of care, and those under 65 years of age. Individual, group activities and regular events are offered. There are regular outings/drives, for all residents and these are conducted in line with MOH Covid-19 guidelines. The weekly planner sighted included, board games, word games, bingo, movies, pet therapy, story reading, art and craft, social van rides, exercises and news and views. Residents and family were consulted in the development of a planner.</p> <p>Activity progress notes and social activity attendance register are completed daily. The residents were observed participating in a variety of activities on the audit days. There is an atrium with a coffee machine available for residents and their families to use for various functions if required. Family members reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Each resident's care plan and interRAI assessment is evaluated, reviewed, and amended either when clinically indicated by a change in the resident's condition or at least every six months whichever is earlier. The evaluations reflected the achievement of the resident set goals over the previous six months. The evaluations are carried out by the RNs in conjunction with family, residents, GP, and specialist service providers.</p> <p>Where progress is different from expected, the service responded by initiating changes to the care plan. Short-term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whānau are included and informed of all changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents and family/whānau are supported to access or seek a referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP and the nursing team refer to specialist service providers and the DHB. Referrals are followed up regularly by the GP and clinical manager. The resident and the family are kept informed of the referral process, as verified by documentation and interviews.</p> <p>Acute or urgent referrals are attended to, and the resident is transferred to the public hospital in an ambulance if required.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The facility policy describes safe and appropriate storage and disposal of waste, infectious or hazardous substances, including storage and use of chemicals. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant staff training. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. No hazardous substances were detected on site. The clinical manager, chef, laundry/cleaning personnel and care staff interviewed demonstrated awareness of safety and appropriate disposal of waste. Used continence and sanitary products are disposed of appropriately in appropriate disposal containers stored in a safe place outside.</p> <p>There were sharps boxes in the medication room. Toiletries and cleaning chemicals are locked up in a room. Personal protective equipment was readily available. Staff was observed to be using personal protective equipment, including changing gloves after every procedure.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The current building warrant of fitness was displayed and expires on 23 November 2022. Annual electrical testing is completed by a certified electrician, and this was confirmed in documentation review, interviews with maintenance personnel, and observation of the environment. Calibration of scales and medical equipment occurs annually, and there were documents to support this. The service has two eight-seater vans, one with wheel-chair access with a current vehicle warrant of fitness and registration in place.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Hot water checks are conducted monthly, with all readings below the maximum temperature range.</p> <p>The corridors are wide enough to enable mobility aids and fitted with handrails to encourage independent mobility. Most resident rooms have direct external access to courtyards and garden areas. There are concrete ramps to enable disability access. Residents can walk around freely throughout the facility and grounds. The gardens and courtyard were well maintained and tidy.</p> <p>Environment hazards are identified and monitored as per the health and safety system. Residents and staff confirmed they know the processes they should follow if any repairs or maintenance are required, any requests are appropriately actioned, and that they are happy 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 are adequate numbers of accessible bathrooms and toilet facilities throughout the facility. Sixteen resident rooms (care suites) have their own ensuite and one hospital room has an ensuite. The toilet's doorways are wide and accessible for residents who require mobility aids. There are secure handrails for the residents to use for support and to promote residents' independence. Each toilet door is lockable with working 'engaged/vacant' signs for privacy. Each bedroom has a hand basin. Toilets, bathrooms, and showers had doors or curtains to provide privacy for users. Toilets, bathrooms, and showers were clean and well maintained. Visitor and staff toilets are available throughout the facility.</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 bedrooms safely. There are 29 single bedrooms with a hand basin, three double rooms, with single occupancy. Personal privacy is maintained and residents in double rooms have screens in between for privacy where required. Rooms are personalised with furnishings, photos, and other personal items displayed. Doorways are wide enough for wheelchair access if required. There was space for mobility aids. Residents with mobility aids were observed to be moving in and out of the rooms with ease. Staff and residents confirmed the adequacy of bedrooms.</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>	FA	<p>Communal areas are available for residents to engage in activities and are kept warm by heat pumps and the atrium has ceramic heaters in place. The bedrooms have heat pumps and wall heaters. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy if required. Furniture is appropriate to the setting and residents' needs.</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>	FA	<p>All laundry is washed on-site or by family members if requested. The family/whanau interviewed expressed satisfaction with the laundry management and the clothes are returned in a timely manner. Material safety data sheets for each of the products were readily accessible. There is a clear separation of clean and dirty areas in the laundry. There are two laundry staff members, one permanent and the other works on part time basis. The laundry department runs seven days a week. Adequate stock of personal protective equipment (PPE) were sighted, and staff were knowledgeable on infection control practices. The staff attends chemical safety training annually</p> <p>There are designated cleaning personnel who have received appropriate training. Chemicals</p>

		<p>were decanted into appropriately labelled containers. The staff attends chemical safety training annually. The effectiveness of cleaning and laundry processes is monitored through the internal audit programme and corrective actions are acted upon. All residents and family members interviewed reported that the environment was clean and were satisfied with laundry services.</p> <p>Cleaning trolleys were kept locked in the two storerooms at the facility. The cleaner interviewed was able to outline infection control practices around cleaning. Cleaning has been increased during Covid-19 pandemic. Records of attendance to IPC training was sighted. Staff wore required PPE during their day-to-day duties</p> <p>All residents and family members interviewed reported that the environment was clean and were satisfied with laundry services.</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>	FA	<p>The facility has an approved evacuation plan, and an evacuation policy is in place. A fire drill takes place every six months and the most recent was conducted in February 2022. All staff complete fire training and participate in a fire drill. Orientation for new employees includes emergency and security training. Staff demonstrated awareness of emergency procedures. There is always at least one staff member on duty with a first-aid certificate. Almost 90% of staff have a current first aid certificate.</p> <p>There are adequate fire exit doors, and the courtyard is the designated assembly point. All required fire equipment is checked within the required timeframes by an external contractor. A civil defence plan was in place. Adequate supplies in the event of a civil defence emergency including food, water, candles, torches, and a gas BBQ meet The National Emergency Management Agency recommendations for the region. A generator is available for hire if required. Two backup batteries are kept fully charged in the power room. Emergency lighting is regularly tested.</p> <p>A security check is done by the afternoon and night staff where all doors are locked. The facility is monitored by CCTV mainly in public and outside areas. External lighting is adequate for safety and security. Call bells alert staff to residents requiring assistance. The call bell system is operational with bells in each room. Those tested on the days of the audit were working and staff responded to call bells promptly. Residents interviewed confirmed that staff attends promptly when a bell is activated. There are labels on the walls to indicate call bells.</p>
Standard 1.4.8: Natural Light, Ventilation,	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms

<p>And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>have natural light, opening external windows and some have doors that open onto the outside garden or small patio areas. Heating is provided by heat pumps and wall heaters in residents' rooms and the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. The service has an external designated covered smoking area away from the building for residents and staff who smoke.</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>	<p>FA</p>	<p>Ons Dorp has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. A senior RN is the designated infection control nurse for the organisation, with support from the clinical manager. Infection control is linked to the quality meeting and includes discussion and reporting of infection control matters. The infection control programme has been reviewed annually. Minutes of meetings are available for staff. Education is provided for staff as part of the service education programme.</p> <p>The service has well developed plans for contingency with regards to the various Covid-19 alert levels. There are sufficient supplies of personal protective equipment (PPE) on hand, and training around infection control, hand hygiene, and donning and doffing of PPE has been provided to staff. Isolation kits are available for use.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme, for the size and complexity of the organisation. The infection control nurse maintains her practice and has completed training. Ons Dorp has external support from the WDHB infection control nurse specialist, and the local hospital. Staff interviewed were knowledgeable regarding their responsibilities for standard and additional precautions.</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</p>	<p>FA</p>	<p>Infection control policy and procedures are appropriate to the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed by an external contractor and are reviewed and updated annually by the clinical manager, then discussed with the quality & risk team. Policies and procedures are reflective of Covid19 guidelines and procedures. A pandemic plan is documented, which includes Covid19.</p>

appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. The clinical manager, the infection control nurse, and external providers, who provide the service with current and best practice information, facilitate this. All infection control training is documented, and a record of attendance is maintained. Discussion of infection prevention is documented in resident meeting minutes.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection surveillance policy. Monthly infection data is collected for all infections. The infection prevention and control nurse receives surveillance data that is collated monthly, including strategies for corrective actions. An infection report and short-term care plan is available for recording infections. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly, annually. Outcomes and actions are discussed at quality and management meetings.</p> <p>Reports are easily accessible to the manager and to organisational management. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure that the use of restraint is actively minimised. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. Enablers are voluntary. There is one resident with restraint and one with an enabler. Staff are trained in restraint minimisation, challenging behaviour and de-escalation and competencies are completed.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on</p>	FA	<p>A restraint approval process and a job description for the restraint coordinator/RN are in place. The resident/family/whānau as appropriate are consulted prior to the use of restraint and receive written information on restraint use. The GP is involved in the approval process. Two care plans were reviewed; one for a resident with a lap belt restraint and one for bedrail enabler identified the use of restraint/ enabler and included an assessment and consent. Healthcare assistants interviewed were knowledgeable on the use of restraint and approval processes.</p>

restraint use and this process is made known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The need for restraint is assessed and agreed by the GP, family, and restraint coordinator. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool meets the requirements of the standard. One resident file where restraint was being used was selected for review. The file included a restraint assessment completed by a RN / restraint coordinator. The consent forms were signed by the resident's family and GP. Restraint use is linked to the resident's care plan;</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>A restraint register is in place. The register identifies the residents that are using a restraint and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and ongoing evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. The service monitors and logs all resident interventions that may inhibit resident movement. This includes all residents with sensor lights, low beds, bed levels and landing mats (as examples).</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>All residents documented on the restraint log (including residents using restraint, enablers, low beds, sensor mats etc) are reviewed monthly by the restraint coordinator and reported to the quality meeting. Restraint and all residents on the restraint register are reviewed six-monthly as part of the care plan review. The review process includes discussing whether continued use of restraint is indicated.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint programme, including reviewing policies and procedures and staff education is evaluated annually by the restraint coordinator and clinical manager as part of the internal review. Restraint audits identify opportunities for improvement (link 1.2.3.6).</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	There is an implemented internal audit system which included annual resident surveys. Internal audits have been undertaken as per the schedule as has the resident survey. Audits are followed up and service gaps followed up and signed off as needed. Quality meeting did not all document the internal audit outcomes and the resident survey had not been collated and reported to respondents	<p>i). Internal audit outcomes are not consistently reported to the quality meetings (safety audit, the restraint audit, complaints, and the Code of rights audit as examples)</p> <p>ii). The most recent residents survey had not been collated and results communicated to respondents.</p>	<p>i). Ensure that internal audit it comes are reported to the quality meetings.</p> <p>ii). Ensure the residents survey is collated and results communicated to respondents.</p>

				90 days
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Low	<p>There is a documented policy, procedure, and forms around post fall neurological observations. Ten unwitnessed falls incidents were reviewed. All 10 had documented post fall follow up, including changes to care interventions updated, and falls minimisation strategies, however not all neurological observations were completed.</p>	<p>Of ten unwitnessed falls, four did not have the neurological observations documented according to policy.</p>	<p>Ensure the neurological observations are documented according to policy</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>During 2020 it was recognised that resident related falls were high and were related to a group of frequent fallers. Bruises were also noted to be higher than expected and were related to falls and also manual handling.</p> <p>Two projects were commenced to reduce the incidence of falls and for bruises, both projects utilised recognised quality process such as process diagrams and root cause analysis. Evaluation of the projects and outcomes were reviewed and evaluated through health and safety meetings, hand overs and staff discussion regarding individual residents.</p> <p>For falls, interventions included physio falls assessments, a documented transfer plan indicating the falls risk, sensor lights in the resident's room (sensing movement and alerting staff to assist the resident), landing mats and low beds, personal alarms, review of activities in the lounge, and the removal of sensor mats (as it was noted that residents tried to avoid treading on them).</p> <p>For bruising, interventions included the development of staff manual handling champions, (these staff are paired with new staff to assist the</p>	<p>Falls have reduced and continue the downward trend. During 2020 there were an average of 16 falls a month, for 2021 and 2022 to year to date, falls have averaged 10 falls a month.</p> <p>Bruises have documented similar reduction - during 2020 there were an average of 12.3 bruise related incidents recorded, this has reduced to 11.5, for 2021 and 2022 year to date, and the last months average is 5.1 falls a month.</p>

		training of new staff), quarterly toolbox training sessions by the physio, ad hoc audits of correct hoist use, limb protectors, and the use of the transfer plans in each resident's room. Staff education noted that staff should 'allow time for the resident to readjust their body'	
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End of the report.