Orongo Lifecare Limited

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:	Orongo Lifecare Limited
Premises audited:	Orongo Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 5 August 2015 End date: 6 August 2015

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: 43

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

Orongo Rest Home is an aged care facility that has a 31 bed rest home and 15 bed secure specialist dementia unit. At the time of audit the dementia unit was full and there were 28 residents living in the rest home. Residents and families report high satisfaction with the quality of care and services at Orongo.

A full certification audit was conducted against the Health and Disability Services Standards and the services' funding contract with the Waitemata District Health Board (DHB). The audit process included an offsite review of organisational polices. The onsite audit included the review of documentation and residents' files, observations and interviews. Interviews were conducted with management, staff, residents, families and a general practitioner. There were informal interviews and feedback from residents living in the dementia unit.

There were two shortfalls identified at this audit. These are related to documentation of pain assessments and maintaining full records of medication administration.

Consumer rights

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

The service has processes in place that demonstrate their commitment to ensuring residents' rights are respected during service delivery. Staff knowledge and understanding of residents' rights is embedded into everyday practice as observed during the audit. Residents and family are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights) and advocacy services clearly displayed and accessible throughout the facility.

Residents are provided with care and services that maximises each person's independence and reflects the residents' and their families' wishes. Policies, procedures and processes are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

Residents who identify as Maori and from other cultural groups have their needs met in a manner that respects and acknowledges their individual and cultural values and beliefs.

Residents receive services of an appropriate standard for rest home and dementia level of care that reflects good practice. The service provides an environment that encourages good practice.

Staff communicate effectively with residents and the right to full and frank information and open disclosure was demonstrated. The service demonstrates that written consent is obtained, which includes written consents from families of residents living in the dementia unit. The residents are able to maintain links with their family and the community. Residents have access to visitors of their choice.

The complaints process is easy to access and meets the rights of the residents and their family/whanau. There are no open complaints at the time of audit.

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.

The organisation's mission statement and vision have been identified in the business and strategic plan. Planning covers business strategies for all aspects of service delivery in a coordinated manner to meet residents' needs. The governance and management teams regularly review the business, risk and quality plans.

The quality and risk system and processes support safe service delivery. Corrective action planning is implemented to manage any areas of concern or deficits identified, with documentation showing the evaluation and follow up of the corrective actions. The quality management system included an internal audit process, complaints management, resident and relative satisfaction surveys and incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff.

There are recruitment and employment practices that reflect best practice in human resource management. The orientation process and ongoing education programme meet the requirements of the standards, contractual requirements with the DHB and needs of the staff and residents. The service implements staffing levels and skill mix to ensure contractual requirements are met.

Records are securely secured. There is no information of a private nature on public display.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.

The residents receive timely, competent and appropriate services that meet their assessed needs and desired outcome/goals. Staff has current practising certificates. The residents are admitted within 24-48 hours with the use of standardised risk assessment tools. Short term care plans are consistently developed when acute conditions are identified. The long term care plans are reviewed six monthly. The contents of the hand over are comprehensive and staff demonstrate good knowledge regarding resident's current condition and treatment.

The planned activities are appropriate to the needs, age and culture of the residents. Activity plans are personalised and reflect the assessed needs and preferences of the resident. The 24-hour activity plans are in place for the dementia unit residents.

Medication management policies reflect legislation, standards, guidelines and best practice. All medication charts reflect three monthly reviews. There are no expired or unwanted medications. The controlled drug register is current and correct.

The service provides meals that met the individual food, fluids and nutritional needs of the residents. The served meals are well-presented. The resident's weights are stable. Modified diets are provided by the service.

Two short falls are identified. Pain assessments were not consistently documented and medication administration records did not include the dose given.

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 service has two rest home wings and a safe and secure environment for residents living with dementia in another wing. The rest home and dementia units are separated from each other and each has their own amenities and external garden areas. The dementia unit provides a secure environment for residents with cognitive impairment to wander freely.

There are documented emergency management response processes which were understood and implemented by staff. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The building has a current building warrant of fitness. There is an approved evacuation scheme and ongoing maintenance plans.

There are appropriate cleaning and laundry services.

The facility provides furnishings and equipment that is appropriate to the level of care provided and is regularly maintained. There are adequate toilet, bathing and hand washing facilities located in each wing. There are designated lounge and dining areas meet residents' relaxation, activity and dining needs.

The building is suitably heated, cooled and ventilated. The outdoor areas, gardens and verandas provide suitable furnishings and shade for residents’ use.

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.

The service has clear and comprehensive policies and procedures which meet the requirements of the restraint minimisation and safe practice standard. There are systems and practices for the assessment, approval, monitoring, evaluation and review of any type of restraint. Restraint in-service training is conducted annually. The staff has good knowledge regarding restraints and enablers.

There are no residents on restraint or enabler.

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.

Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. Policies reflect current accepted good practice and are readily available for staff. Infection control in-service training is provided regularly. The type of infection surveillance is appropriate to the size and complexity of the service. Infection rates are collected, recorded, analysed and reported to staff and management. Recommendations to reduce infection rates are discussed in staff meetings. Staff and residents are offered annual influenza vaccinations.

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 AttainedStandards applicable to this service 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	42	0	2	0	0	0
Criteria	0	91	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Staff demonstrated knowledge and understanding of respecting resident rights. Care and services are delivered in a flexible way to respect resident's choices. Staff were observed to be respectful and maintaining resident's privacy. Staff receive training on resident's rights as part of their orientation and ongoing education. Staff gave examples, such as asking if the resident was ready to be assisted with a shower, knocking on the residents doors and asking permission to enter the resident's room.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	All files have written consent forms, these include general consent to personal and nursing care, primary medical care, allied health, personal and health information informing family/whanau, activities and outings, identification and health information release. There are also consents to specific treatments, such as the flu vaccination. There are processes in place for the Enduring Power of Attorney (EPOA) to sign consent forms for the resident's living in the dementia unit. The resident's files reviewed have health care directives if the resident wishes cardiopulmonary resuscitation (CPR) to be undertaken. One file

		reviewed had an advance directive. Management and staff are aware of acting on valid advance directives. Staff also understand the consent process and the resident's right to refuse interventions. The residents and families did not express any concerns with the consent processes and feel their right to choose is respected.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	The residents' files and interviews with family confirmed that the service actively encourages residents to participate fully in determining how their health and welfare is managed. Family are encouraged to involve themselves as advocates and an advocate from the Nationwide Health and Disability Advocacy Service visits the service regularly. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the resident admission information along with local advocacy services information. The advocate provides ongoing information and education to residents and staff.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents state they have access to visitors of their choice. Residents are encouraged and supported to maintain and access community services along with friends and family. Residents' files identified that regular community outings occur. Residents go out with friends and family and the community services also visit the facility.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Complaints forms are accessible and displayed throughout the service. Staff demonstrated knowledge on the complaints management process. The complaints sighted were addressed within times frames outlined in Right 10 of the Code. The service has a concerns and complaints register, this records any concerns/complaints, date and a brief description of the actions taken. Any concerns or complaints that are received each month are discussed at the quality meeting. The residents and families reported that if they wished to make a complaint, the process is easy and they feel that any concerns are listened to and addressed. There has been one external complaint through the Health and Disability Commissioner since the last certification audit. This is now closed with appropriate actions related to communicating changes to family implemented and observed to be embedded into practice.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	A copy the Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) is given and explained to residents and their family as part of the admission process. The admission process also includes information on advocacy services. The Nationwide Health and Disability Advocacy Service brochure and contacts are on display. The advocate conducts education for residents and staff. The residents sign a form to say they have received and understand the Code and advocacy. The Code is displayed throughout the service and there is also a copy of the Code available in other languages and on video.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	All rooms are single occupancy to maintain resident's privacy. The residents and families spoke highly of how all staff respect their independence, privacy and treat them with dignity and respect, and had no concerns with abuse and neglect. Each resident's file identifies any specific individual needs of resident's related to cultural, religious or personal beliefs. The staff gave examples of how they respected residents' independence, dignity and privacy.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The services has a Maori Health plan. The manager reported there are no barriers to Maori residents accessing the service. The residents who identify as Maori have their needs and beliefs recorded in their care plan. Staff demonstrated knowledge of individual beliefs and the importance of whanau. They gave examples of how whanau are involved in the residents' care and activities.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	There are general guidelines to assist staff in the assessment and delivery of services that will meet residents' cultural and spiritual needs. Residents receive services that take into account their cultural and individual values and beliefs. Residents and family members confirmed they are consulted on their relative's individual values and beliefs and that care is planned and delivered to meet individual resident's needs. This covers social, spiritual, cultural and recreational needs. Family are involved in the development and review of the care plan.
Standard 1.1.7: Discrimination	FA	Staff files, the staff handbook and individual employment contracts include information about expected behaviours and professional

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.		boundaries. Staff are given information on the code of conduct that identifies that staff maintain professional boundaries and refrain from acts or behaviours which could be deemed as discriminatory. The nursing staff have completed the required nursing code of conduct education. Residents and family members confirmed they have no concerns related to discrimination, coercion, harassment, sexual, financial or any other form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	There is regular in-service education and staff access external education that is focused on best practice, with all educational material sighted showing evidence of being relevant to current best practice standards. Interviews with staff confirmed that the environment in which they work encourages good practice. All staff are supported by management and have access to evidence based policies and procedures and appropriate ongoing education. Interviews with family and the GP confirmed their high level of satisfaction with all care delivery and staff attitude. This is further supported by the results of the recent resident satisfaction survey.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Policy related to open disclosure is implemented by the service. Residents and family members confirmed they are kept informed of the resident's status, including any adverse events, incidents or concerns staff may have. Family communication is clearly documented in the residents' files, on incident and accident forms and in the staff communication book. The family, residents and general practitioner (GP) report that communication is strength of the service. Wherever necessary and reasonably practicable, interpreter services are provided. Contact details for the interpreter service are clearly set out in resident admission information and in policy.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Services are planned to meet the needs of residents requiring rest home and specialised secure dementia care for up to 46 residents. There is a 15 bed dementia unit and a 31 bed rest home section. There were 15 residents in the dementia unit and 28 rest home residents at the time of audit with one rest home resident receiving palliative care, in which the service has applied for dispensation from the Ministry of Health to continue to provide care to the resident in their end stage of life. The manager, register nurse (RN) and care plan review confirmed

		that the resident is receiving the appropriate level of care at Orongo. The organisational purpose, vision and mission is clearly recorded in policy, the business plan and quality plan. The monthly governance meetings sighted provide a review of the service and performance against the business and quality plans. The organisation conducts an annual evaluation of the service and performance and goals in the quality plan. The areas of evaluation include service delivery, resident and family satisfaction, risk management, health and safety, training and human resources. The evaluations record that the service is meeting their goals and identifies future development and new initiatives to make future improvements to the organisation and service delivery. The manager is a suitably qualified and an experienced enrolled nurse. They have been the manager of the facility for over eight years. Their job description describes their roles, responsibilities and authorities. The manager reports to the director of the organisation. The manager is also supported by the manager from another facility and an onsite clinical nurse leader (RN). The manager attends ongoing education on management of a care facility and other clinical education related to dementia care and the aging process. Residents and families report satisfaction with the care and services provide at Orongo.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The clinical nurse leader (RN) fills in for the manager during temporary absence. The RNs job description identified that this is part of their role. The manager reports confidence in the RNs ability to fill in during their temporary absence.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Staff are actively involved in the quality programme and demonstrated an understanding of what the organisation aims to achieve. The quality committee meetings minutes were made available to staff. Staff confirmed they understood and implement the quality and risk management systems. All policies and procedures sighted were up to date, reflected current good practice and met legislative requirements. The organisation

		currently reviews all documents in a two yearly cycle. All documents have a version control footer that includes the date when the policy was last reviewed. The document control system ensured that obsolete documents were removed from use. The review of policies occurs at the monthly quality committee meeting. Recent policy updates include the implementation of the interRAI assessment and care planning. The organisation had a documented quality and risk management plan which identified risks and showed the strategies in place to manage risks. All potential and actual risks were reported at board level and reviewed regularly. Clinical risks were discussed monthly at staff meetings as confirmed in meeting minutes sighted and confirmed by staff. There was an up to date hazard register and the process for reporting hazards was understood by staff interviewed. Quality data collection and analysis was maintained by the service and evaluation of results shared with staff and management. Quality improvements were put in place where indicated. When the internal audit or quality data indicates any shortfalls, corrective actions are put in place. The internal audit form records the identified issue, actions needed, who is to implement the actions and the review of when the actions have been implemented. Staff confirmed that all follow up actions were discussed during handover and at regular staff meetings. Data was collected, trended, reviewed and evaluated for all key components of service (complaints, incidents and accidents, health and safety, hazards, restraint and infection control). The risk, hazard and emergency response plan identifies potential and actual hazards. The plan includes what the hazard is, risk level, preventative actions and ways to minimise risk.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The manager understands their obligations for reporting serious harm and essential notifications. There have been no incidents or accidents that have required essential notification since the last audit. The service has applied to the Ministry of Health for dispensation for a resident receiving palliative care. Staff demonstrated knowledge of when they are required to complete an incident/accident form. There is a monthly analysis of the incident and accident reports. The analysis of the incidents and accidents are used to implement improvements as indicated. The analysis includes the numbers of falls and the times that

		falls are occurring for residents who have had increased falls, with strategies implemented to reduce the number of falls.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Professional qualifications and annual practicing certificates (APCs) are validated on employment and annually. The service maintains a folder of current APCs, sighted for all staff and contractors who require them. The staff files evidence that good employment processes are implemented, such as recruitment, interview and reference checking. After the orientation period there is a performance review at three months, six months then annually, as confirmed in the staff files reviewed. The orientation and induction programme is conducted over a six week period. There is an initial two day orientation that all new staff complete, then role specific orientation for the different roles within the services (eg RNs/ENs, caregivers, kitchen staff, cleaning, laundry, activities). The initial general orientation includes the essential and emergency systems, handling concerns and complaints, cultural best practice, infection control, incidents/accident reporting, managing challenging behaviours and restraint minimisation. Each staff file reviewed evidenced an orientation and induction into their role. Staff reported that the orientation and induction gave them a good understanding of their role and responsibilities. The in-service education programme covers the essential components of service delivery for rest home and dementia level of care. The service also accesses ongoing education support from the DHB, gerontology nurse specialists and palliative care services. All care staff who work in the dementia unit have completed the required national unit standards for dementia care. Attendance records are kept for the education that staff have attended, as sighted in each of the staff members personnel file. Staff also have access to self-directed learning packages as part of the education and competency assessment system. Written medication competencies were sighted for the nursing staff and some senior care givers. The clinical nurse leader has completed their interRAI competency training. Staff reported that they are supported and encouraged with maintaining their knowledge

		and skills.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is clearly documented policy on staffing levels and skill mix to meet the needs of residents requiring rest home and secure dementia level of care. There is at least one RN on duty six days a week. When an RN is not on duty, there is an EN or senior caregiver on duty. After hours the on call role is shared with the RNs and manager (EN). If the manager needs further clinical advice after hours, they also have access to one of the RNs. There are five to six caregivers on duty on morning and afternoon shifts. There is at least three caregivers on duty for night shift, this allows for one staff member to always be in the rest home and dementia unit sections at all times. There is at least one staff member on duty each shift who has current first aid qualifications. There are appropriate staffing level for activities, cooking, cleaning and laundry. Staff confirmed they have adequate time to do their required work and all staff assist in implementing meaningful activities for the residents throughout their shifts.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents' files identify that information is managed in an accurate and timely manner. Health information is kept in secure areas at the nurses' station and is not accessible or observable to the public. Electronic records are secured and password protected. Entries into the progress notes record the staff member's name and designation. All records pertaining to individual residents are integrated. The service uses a mix of electronic and paper based records, with the relevant electronic assessment (interRAI) printed and a copy placed in the resident's hard copy folder. Hard copy records are securely stored on site and there is electronic archiving and back up for the electronic records.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The entry to the service policy outlines all entry requirements and the procedures to be followed on admission. Both telephone and walk-in enquiries were recorded in the enquiry register. All residents have the appropriate needs assessment prior to admission. The welcome pack contains appropriate information about the service. In interview, the manager confirmed that they accept residents as per contractual requirements. The required admission agreements were sighted. In interview,

		residents and family reported that the admission process, and admission agreement, were discussed in detail on enquiry/entry.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a documented exit process. The process captures the resident's current capabilities and identified risks The CNL reported that a telephone handover was conducted for all transfers to other services. Residents and families confirmed they were kept informed for all exit or discharges to and from the service.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	The required medication management policies are in place. Medication charts sampled had evidence of three monthly reviews. Discontinued medications were signed and dated by the GP, allergies were well-documented and photos were present. Prescriptions were written legibly. The registered nurses conduct medication reconciliation on admission or when a resident is discharged back to the service. All staff who administer medications have current medication competency. Medication competencies were conducted annually and medication in-service training was provided. Medication administration charts were utilised, however the actual dose of the medication administered was not consistently recorded. All medications were stored appropriately. There were no expired or unwanted medications sighted. Expired medications were returned to the pharmacy in a timely manner. The controlled drugs register was current and correct. Weekly stocktakes were conducted. There were no residents who self-administered their medications. Self-administration policies and procedures were in place.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Policies and procedures included the principles of food safety, ordering, storage, cooking, reheating and food handling. Staff infection prevention and control requirements were also detailed. All meals were prepared and cooked onsite. All cooks have current food handling certificates. Residents were provided with meals that meet their food, fluids and nutritional needs. Registered nurses completed the dietary requirement form on admission and provided a copy to the kitchen. The CNL or manager updated the kitchen board regularly. The service also provided additional or modified foods depending on the need of the

		residents. Fridge and food temperatures were monitored and recorded daily. Cooked meals were transported to the dining areas. The meals were well presented and residents confirmed that they were provided with alternative meals as per requested. All residents were weighed regularly.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	There is a documented policy on decline of entry. It was reported that when entry to the service was declined, the resident was referred back to the referrer to ensure that the resident will be admitted to the appropriate service provider. This was evident in the declined entry to the service register. Potential residents were also referred to nearby facilities within the area who can provide the appropriate level of care. The manager reported that the district health board needs assessors and social workers have contacted the manager to discuss the suitability of the resident prior to sending the resident's family to view the facility.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low	Registered nurses utilised standard risk assessment tools on admission, however not all assessments had been completed as required. Assessment information was utilised when developing the long term care plan. Admission assessments were conducted within the specified timeframes. A number of additional assessments were completed, for example medical assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Long term care plans were resident-focused and have evidence of input from other members of the health team. Goals were resident focused, specific and measurable towards addressing the identified issues. Interventions were sufficiently detailed to address the desired goal/outcome. Long term care plans were user friendly and were easy to comprehend. Long term care plans were updated when the interventions were not effective, and at six monthly reviews. Short term care plans were documented in the event the resident developed an acute infection. Residents and family members confirmed that they were involved with the care planning process. Staff reported that they were informed of any changes to care plans during hand overs and at staff meetings.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documented and implemented interventions were sufficiently detailed to address the assessed needs and desired goals/outcomes. Interventions for managing acute conditions were documented in short term care plans. Interventions were changed when the desired goals/outcomes were not met, or when the resident's response to the treatment was not satisfactory. Interventions in the dementia unit were consistent with the needs and behaviours of the residents.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	A range of activities were provided in the rest home and dementia unit. There is one activities coordinator for both services. The coordinator develops the yearly activity plans with the manager and the residents. All activity plans are signed off by the registered nurse. Weekly activities were posted in the rest home and dementia units as well as in the main entrance board. The activities coordinator reported that the activities boards were updated daily. The rest home and dementia unit residents have different activity programmes with the dementia unit having more one on one session. All residents had well-documented activity plans that reflected the resident's preferred activities and interests. The 24-hour activity plans in the dementia unit were sufficiently detailed to guide the staff in managing activities with the residents. Records of individual participation in activities was maintained.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Short term care plans are evaluated by the registered nurses. Resolutions of acute conditions were well-documented. Long term care plans were reviewed and evaluated every six months or earlier as required. Long term and short term care plans were modified or changed when the outcomes were different from expected. The residents and family members confirmed they were given the opportunity to be involved in all aspects of care and reviews/evaluations. In interview, staff demonstrated adequate knowledge regarding long term and short term care plans as well as the required evaluations.
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	FA	There were documented policies and procedures in relation to exit, transfer or transition of residents. The service utilises a standard referral form when referring residents to other service providers.

disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		Records sampled confirmed timely referrals by the GP to other specialist services. Resident and families confirmed that they were kept informed of referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	The cleaning, laundry and sluice room have safe, secure and appropriate storage of waste, chemicals and hazardous substances. Personal protective equipment (PPE), such as gloves, disposable gowns, and eye protection is available in each storage area. The cleaning and laundry staff demonstrated knowledge on the safe use of the chemicals and PPE. Staff have ongoing education on infection prevention and control and the use of chemicals.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service has a current building warrant of fitness displayed. Hot water temperatures were monitored monthly, these being within safe guidelines. Medical equipment has annual calibration, last conducted with the last year. The electrical equipment is test and tagged, last conducted in February 2015. The annual service of the wheelchairs and hoist is sighted. The radiators in each resident's rooms and hallways and call bell systems are serviced and checked at least annually by external contractors. There is some wear and tear of some of the surfaces in the servery area and a shower in the dementia unit; this is on the maintenance list to be repaired. The environment promotes safe mobility, with secure hand rails in the hallways and floor surfaces that are intact and do not present a trip hazard. Each wing has access to the external areas. The dementia unit external area is separated from the rest home section of the service. The residents and families reported satisfaction with the environment.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There is one room with ensuite facilities. Each of the three wings has centrally located toilets and shower facilities. There are three toilets and two showers in each wing. One rest home wing also has a bath. All of these facilities have privacy locks and signage. The surfaces in the shower and toilet facilities in Totara wing are showing signs of deterioration, with these being repaired at the time of audit. The residents and families report satisfaction with the facilities at Orongo.
Standard 1.4.4: Personal Space/Bed Areas	FA	All rooms are single occupancy and suited to the needs of residents at

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		rest home level of care. The rest home and dementia units are separated. Each resident's room has their personal items and provides enough space for the resident and staff to mobilise. The residents and families report satisfaction with the personal space.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Each wing has an open plan lounge and dining area. The layout of the furnishings separate the activities in each of these rooms. Resident rooms also provide areas for residents to relax or entertain in privacy. The residents and families report satisfaction with the access to dining and lounge facilities.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The chemical supplier conducts a monthly service and inspection of the cleaning and laundry processes and effectiveness of the chemicals. The supplier also conducts a monthly inspection of the housekeeping areas, such as carpets, floors and toilets, with all these evidencing a good housekeeping rating. Each wing has secure storage of chemicals in each sluice room. There is additional secure storage of the bulk chemical supply in a storage room. Each of three wings has their own storage areas, with the sluice and chemical storage in the dementia unit having an additional lock located high on the door. Staff demonstrated knowledge on the use of chemicals. The residents and family report satisfaction with the cleaning and laundry services.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The approved evacuation scheme is dated 2005. The fire and emergency equipment has a monthly inspection as well as an annual certification by an external contractor. Emergency and security training is provided as part of staff orientation and ongoing in-service education. Evacuation drills are conducted six monthly, with the last conducted in March 2015. Staff demonstrated knowledge on how to respond in emergency or civil defence situations. The service has a diesel generator for power and lighting in the event of mains failure. There is a water tank and bottled drinking water that is accessible in emergency situations. Each room, toilet and bathing facility has access to a call bell. The call bell system has a light and audible alert when activated. Staff responded promptly when the call bell was tested. The residents and families report satisfaction with the time frames in which call bells are

		answered. The layout of the dementia unit allows for residents with cognitive impairment to wander freely inside and into the secured garden area. At night a senior staff member has a checklist to ensure the entrances, doors and windows are secure. After hours visitors are required to use the doorbell to gain access to the facility. Staff, residents and families report satisfaction with the security arrangements.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All areas used by residents and families are ventilated and heated. The facility was warm at the time of audit. Each resident's room and hallway have wall mounted radiators and at least one window or sliding door for light and ventilation. The residents and family report satisfaction with the heating, light and ventilation.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The responsibilities for infection control were clearly defined. The clinical nurse leader (CNL) was the delegated infection control co-ordinator and had signed the appropriate job description. The CNL was responsible for gaining infection control/infectious disease/microbiological advice and support, including advice from the Waitemata DHB gerontology nurse specialist. The infection control programme was reviewed annually. The infection control committee have clinical and non-clinical members. Infection control was included in the monthly staff meetings. The Infectious diseases prevention policy was in place to prevent visitors suffering from, or exposed to and susceptible to, from exposing others while still infectious. Resident's families and relatives were encouraged not to visit when they were unwell. Hand sanitizers were in the main reception area as well as in the corridors. Staff interviewed reported that infections were discussed in the staff hand-overs. Infection control policies and procedures were available to the staff in the nurse's station.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs	FA	The CNL was responsible for facilitating infection prevention and control activities in the facility. The CNL attended relevant education on infection prevention and control. The RNs liaised with the GP if there were concerns regarding known or suspected infections. This

of the organisation.		was confirmed by the GP. The district health board gerontology nurse specialist provides expert advice regarding infection control to the CNL. The manager and the CNL were both knowledgeable regarding outbreak management. There was an outbreak management box in place.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There were documented policies and procedures for the prevention and control of infection. Policies were aligned with current accepted good practice and relevant legislative requirements. Policies were readily available and procedures were practical, safe, appropriate and suitable for the type of service provided. The service consistently implemented the policies and procedures and best practice. All interviewed staff demonstrated excellent knowledge on infection control prevention including the importance of proper hand washing. Interviewed residents were able to explain the importance of hand-washing.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Infection control and prevention education was provided to staff as a component of the orientation and ongoing education programme. Infection control in-service education was conducted regularly. Residents and families were provided with advice on infection prevention and control activities. Infection control awareness was included in the resident's meeting. Staff interviewed demonstrated good knowledge in infection control and prevention. The infection control coordinator had current knowledge regarding infection control and prevention in the facility as well as outbreak management.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance for infection rates was carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. This was appropriate to the size and setting of the service. Infection rates were monitored and were collated by the CNL for analysis/trending. Infection rates were discussed during the monthly meetings. The specific recommendations and interventions to reduce, manage and prevent the infections were discussed during the monthly meetings as well as during hand-overs. The uses of antibiotics was monitored and recorded. Infections rates were collated

		for benchmarking and results communicated.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service promotes a restraint-free environment. The manager is the delegated restraint coordinator with relevant authorities and responsibilities. There was a signed restraint coordinator job description. An approval group was established headed by the restraint coordinator. Restraint decisions were in collaboration with the GP. The restraint coordinator was knowledgeable about the restraint process. Staff demonstrated good knowledge regarding restraint and use of de-escalation techniques. All staff were trained/educated regarding the restraint policy and procedures as well as managing challenging behaviours. The restraint register was current and there were no residents using restraint or enablers at the time of the audit.

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.

Citerion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	Medication administration records were sampled. Administration of medication was observed. Not all administration records sampled included the dose of the administered medications.	Staff were not consistently documenting the actual dosage of medication when it is being administered.	Maintain consistent administration records, including dose given. 180 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	There are documented policies and procedures in relation to pain management. These required a pain assessment to be completed for all residents who were prescribed regular pain medication. The required pain assessments were not consistently sighted.	Pain assessments were not consistently sighted for all residents’ prescribed regular analgesia.	Complete pain assessments as required. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.