

# Orongo Lifecare Limited - Orongo Rest Home

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## 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 Q-Audit 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:

<b>Legal entity:</b>	Orongo Lifecare Limited
<b>Premises audited:</b>	Orongo Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 3 July 2018      End date: 4 July 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	38

# Executive summary of the audit

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## 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 provides rest home and secure dementia level care for up to 46 residents. The organisation is governed by a sole owner/director. Day to day management is the responsibility of the manager, who is supported by the clinical manager.

This certification audit was conducted against the Health and Disability Services Standards and the services contract with the district health board (DHB). The audit process included review of policies and procedures, sampling of residents' and staff records, observations and interviews with residents, families, clinical and non-clinical staff and a general practitioner.

There is evidence that the organisation provides safe and effective services. There were no areas for improvement identified during the audit.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Resident rights are maintained in line with consumer rights legislation. All residents are informed of their rights, including access to advocacy services. There is an informed consent process. Values and beliefs are respected. There are processes for the identification, reporting and management of any suspected discrimination or abuse/neglect. Services are provided in line with good practice principals. The complaints process is managed in line with complaints legislation.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Organisation performance is monitored. The mission, vision and values are current. The management team are suitably qualified. There is a documented quality and risk management system. Quality related data is analysed and improvements made where required, Adverse events are well managed. The required policies and procedures are documented.

Human resource processes are in place and support safe service delivery. Staff have the required orientation and education. There are a sufficient number of suitably qualified staff on duty at all times.

Client records are securely maintained and provide the relevant detail. Client files are integrated. Archived records are safely stored for easy retrieval.

## 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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Residents receive timely, competent and appropriate services that meet their assessed needs and desired outcomes/goals. Care plans and assessments are developed and reviewed as required. Planned activities are appropriate to the needs, age and culture of the residents.

The meal service meets the individual food, fluids and nutritional needs of the residents. Residents with special dietary needs are catered for.

A medication management system is in place and all staff members responsible for medicines administration have annual competencies completed. All medications charts are reviewed by the GP every three months or as required.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The environment and building are fit for purpose. Maintenance requirements are met. All equipment and furnishings are in good order. The facility is large and has ample areas to meet the residents' needs. There is a large outdoor area, with a secure area for residents in the dementia wing. All residents have a single room. There are a sufficient number of toilets and bathing facilities. All cleaning and laundry processes are monitored. Emergency procedures and equipment are provided. All residents and family/whanau reported they felt safe and secure.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The dementia wing and grounds provide a secure environment. Residents in the dementia wing are unable to leave the area without being accompanied by a staff (or family) member. All rest home residents are free to come and go as they wish.

There are documented policies and procedures on restraint and enablers. There were no residents using a restraint or enabler at the time of the audit.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control management system minimises the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## 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)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	0	93	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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	All staff receive education on consumer rights legislation. This occurs during orientation and in ongoing education which is provided by a Health and Disability advocate. In interview, staff were able to describe how they incorporated resident rights into day to day practice.
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	The residents' files sampled had consent forms signed by the resident, or when appropriate, signed by the enduring power of attorney (EPOA). The files contained copies of any advance care planning and the resident's wishes for end of life care. Staff acknowledged the resident's right to make choices based on information presented to them.
Standard 1.1.11: Advocacy And Support	FA	Residents and family/whanau reported that they are provided with information regarding access to advocacy services. Families are encouraged to involve themselves as advocates. Contact details for the Nationwide Health and Disability Advocacy Service are listed in the resident information booklet and

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		pamphlets are available at reception. Education on advocacy and support is conducted as part of the in-service education programme.
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	There are no set visiting hours and relatives are encouraged to visit at any time. Family/whanau reported that there were no restrictions to visiting hours. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme.
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints process meets the requirements of consumer legislation. A copy of the complaints process is given to residents during entry. Copies of complaint forms are accessible throughout the facility. Residents and family/whanau interviewed confirmed they would feel comfortable reporting concerns, and confident that their concerns would be followed up. Resident and family/whanau satisfaction surveys sampled confirmed that residents feel their concerns are managed well. All staff receive training on the complaints management process. There were no outstanding internal or external complaints at the time of the audit.  A complaints/concerns register is maintained. This includes verbal and written complaints/concerns. All complaints and concerns are discussed at governance and quality meetings. Records sampled confirmed that all complaints/concerns have been addressed in a timely manner, to the satisfaction of the complainant.
Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights.	FA	Information about the consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code of Rights is available in Maori and English. Residents and families interviewed were aware of their rights and confirmed that information was provided to them during the admission process. The rest home 's information pack outlines services provided. Signed residents' agreements were sighted in records sampled. Service agreements meet the requirements of this standard and district health board requirements.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect	FA	The residents' personal privacy is maintained. All residents have their own room, and support for personal cares is conducted in a respectful manner. This was confirmed in interviews with residents and family/whanau. Individual values and beliefs are documented in care plans. Residents are

<p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>supported to maintain their independence with rest home residents able to come and go as they please. There are documented processes regarding abuse and neglect and all staff receive training. There were no reports of alleged abuse or neglect in the records sampled.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. Family/next of kin input and involvement in service delivery/decision making is sought if applicable. The staff interviewed reported that they understand and have attended cultural training and demonstrated the importance of whanau to Maori residents. The Maori Health plan includes a commitment to the principles of the Treaty of Waitangi and barriers to access. The Maori Health plan also addresses links with a local marae and recognises the importance of whanau. A local kaumatua has agreed to provide the facility with advice and assistance when required, including blessings of rooms. Cultural safety training for staff includes cultural competence, language barriers, body language and valuing our diverse culture. The rest home celebrates Waitangi Day and matariki.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The resident files sampled identified the cultural and/or spiritual needs of the resident in consultation with the resident and family as part of the admission process. Specific health issues and food preferences are identified on admission. The care plan is developed to provide guidance on delivery of individualised support in a culturally and/or spiritually sensitive manner. Staff interviewed reported on the need to respect individuals culture and values. The residents reported that cultural and religious beliefs are respected and reported there is access to church services if they wished to go.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The employment position description and the Code of Rights define residents' rights relating to discrimination. Staff interviewed verbalised they would report any inappropriate behaviour to the clinical manager. The clinical manager reported that formal action would be taken as part of the disciplinary procedure if there was an employee breach of conduct. Residents interviewed confirmed that they felt safe and respected at all times.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The planned yearly education programme includes sessions that cover good practice topics. There is specialist advice available if required. There is regular in-service education and staff access external education that is focused on aged care, dementia care and best practice. Staff reported that they were satisfied with the relevance of the education provided. Policies and procedures are linked to evidence-based practice, there are regular visits by the GP and links with the local DHB. Interventions sighted in</p>

		care plans reflect evidence-based nursing practice.
<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>Documentation of open disclosure following incidents/accidents was evident on incident forms sampled. Family/whanau reported they are informed of any accident or incident and this is documented in the family contact notes.</p> <p>Staff education has been provided in relation to appropriate communication methods. The service has not required any access to interpreting services for the residents. Policies and procedures are in place if interpreter services are needed to be accessed.</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>The organisation is governed by the sole owner/director who has been in the industry for 30 years. The director owns two aged care facilities which share the same management and quality system. The vision and mission are reviewed annually by the manager and director. The service mission is documented in the information pamphlets and is displayed throughout the facility.</p> <p>The annual business plan defines the scope, direction and objectives of the organisation as well as the monitoring and reporting against objectives. The business plan is developed by the director and is reviewed annually. The business plan includes changes in consumer trends, a summary of industry changes, delegations, financial management, quality outcomes, keys to success, review of contracted providers and competitors, marketing and future development.</p> <p>Organisational performance is monitored. There is a monthly governance meeting between the director and the manager which includes reports on all aspects of the service and achievement towards objectives. Governance meeting minutes were sampled.</p> <p>The manager has delegated responsibilities to keep the director informed of any issues or concerns that may impact the business. The manager is an enrolled nurse with a current annual practising certificate and relevant management experience. The manager has managed the service for over 13 years and maintains the required hours needed for professional development. The manager is supported by a clinical manager, who is a registered nurse, with a background in aged care and was newly appointed to the role in April 2018. The current organisational chart is documented.</p> <p>The organisation provides rest home and dementia level of care for up to 46 residents. There is a 15-bed secure dementia unit (Kowhai Wing) and two rest home wings (31 beds). At the time of audit there were 12 residents living in the dementia unit and 26 in the rest home sections. The organisation also has a respite contract with the district health board (DHB). The majority of residents are government funded, with a small number of residents (eight) paying privately.</p>

<p><b>Standard 1.2.2: Service Management</b></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>	<p>FA</p>	<p>The director owns another aged care service in Auckland and the two managers are in frequent contact and provide support for each other. This includes the provision of support and oversight during a temporary absence. The clinical manager fulfils clinical requirements and has access to the clinical manager of the other facility if needed.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a quality and risk management framework which includes a quality plan. The 2018 plan details the quality system, quality structure and sets quality goals for 2018 and includes the directors vision. The manager develops the quality plan and goals, maintains document management and is responsible for monitoring and reporting progress against quality goals in the monthly report to the director. All staff receive an orientation to the quality and risk management system.</p> <p>There is a quality committee that meets monthly. The team includes representation from across the organisation. Meeting minutes were sampled and included discussions and analysis on quality related data, red flags (risk), outputs and inputs, new business and policy/system reviews. Quality data also includes information gained through resident satisfaction surveys. Surveys were sampled and confirmed general satisfaction with the services provided.</p> <p>Policies and procedures were originally developed by an aged care consultant and have been reviewed and amended in an ongoing manner. A full review of relevant policies and procedures was conducted by the auditor prior to the onsite audit, and suggested improvements were subsequently made. There is a system for ensuring that staff are alerted to any changes in the system, and for removing obsolete documents from circulation.</p> <p>There is a comprehensive process for checking ongoing compliance to the quality management system and contract requirements. This includes a range of checklists and internal audits which cover the scope of the system. There is evidence that improvements are made if a short fall is identified. The results of internal audits, and required corrective actions, are discussed at quality and staff meetings.</p> <p>The business continuity and risk management plan includes the identification of actual and potential risks. Each risk is rated against the impact on the service and the likelihood of occurrence. Preventative actions are documented. There is evidence that organisational risks are considered and discussed at governance meetings. A health and safety programme is documented and implemented.</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>	FA	<p>There is a process for reporting and investigating adverse events. Staff interviewed were aware of the adverse event reporting system. The manager was aware of any essential notification requirements. Adverse events are documented on an incident/accident form and are reported to the clinical manager for initial investigation and immediate actions. These are then followed up by the manager for collation, analysis and development of any required corrective actions or follow up. Records of adverse events sampled confirmed that the required immediate actions and notifications have been made.</p> <p>The data related to adverse events is collated and reviewed monthly. This includes a trend analysis. Analysis includes the identification of type (for example fall, skin tear or bruise) as well as the time and place of each event. Where trends and shortfalls are identified, corrective actions are implemented to make improvements to service delivery and individual resident preventive strategies (such as falls minimisation). Collated adverse events sampled provide confirmation that the service has been successful in managing behaviours of concern.</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 policies and procedures on human resources management. These are consistent with good practice and employment legislation and guidelines. The recruitment process ensures that professional qualifications are validated. The skills and knowledge required for each position are documented in position descriptions which were evident in staff files sampled.</p> <p>All staff receive an orientation. The orientation programme covers the essential components of service delivery. New staff work closely with another staff member until they are considered competent to perform their role independently. Mandatory competencies, for example clinical and medication competencies are defined and monitored. Staff performance is monitored. Staff appraisals are conducted at the end of orientation and then annually. Evidence of completed orientation, competencies and performance appraisals were sighted in staff files sampled.</p> <p>Ongoing education is provided. The education plan covers relevant topics and meets the requirements of the DHB agreement. Education is provided in house, on line and by staff visiting external providers. Individual records of education are maintained and confirmed attendance at the required training. For example, care staff who work in the dementia unit have the required training and the clinical manager is trained in the interRAI assessment programme. Staff interviewed reported that they had good access to education and were well supported during their orientation process.</p>
<p>Standard 1.2.8: Service Provider</p>	FA	<p>There is a documented allocation of staff to complete the duty rosters. Rosters sampled confirmed that staffing levels comply with contractual requirements, with staff on leave replaced. There are at least</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>three caregivers on duty in the rest home for morning and afternoon shifts (staggered finish times, with more staff on duty at the busiest times of the shift). There are two staff on duty in the dementia unit mornings and evenings, and at night there is one staff member in the dementia unit and two other care staff in the rest home.</p> <p>Registered nurses are on duty morning shift six days a week and on call at other times. The manager is site Monday to Friday. There are sufficient numbers of support staff (kitchen, cleaning, laundry) to meet the needs of the residents. There is an activities coordinator on site five days per week. The care staff assist with the activities on weekends.</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>All residents have a hard copy file. All resident records are integrated with allied health providers documenting their entries in a separate location in the integrated folder. Clinical records are documented daily, with additional entries as required and from the registered nurses. All records sampled were signed and designated. All records are securely stored. The only publicly accessible resident information is a list of residents' names at the entrance to each wing.</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 welcome pack contains all information about entry to the service and entries are recorded on the initial contact information form. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. Records sampled confirmed that admission requirements were conducted within the required time frames and were signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Interviewed relatives confirmed that they received sufficient information regarding the services to be provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a documented process for the management of transfers and discharges. Standard transfer notification forms from the DHB and activities of living summaries are utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</p>
<p>Standard 1.3.12: Medicine Management</p>	FA	<p>The medication management system complies with legislation, protocols, and guidelines. Residents receive medicines in a safe and timely manner. All medications are reviewed as required and discontinued medications are signed and dated by the GP. Allergies are clearly documented; photo</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>identification was current and three-monthly reviews are conducted. Medication charts are legibly written.</p> <p>The medications and associated documentation are stored safely and medication reconciliation is conducted by the clinical manager when a resident is transferred back to the service. The service uses pre-packaged packs. There were no expired or unwanted medications. Expired medications are returned to the pharmacy in a timely manner. There were no controlled drugs onsite on the day of the audit.</p> <p>An annual medication competency is completed for all staff administering medication and medication training records were sighted. The clinical manager and caregiver were observed administering medications safely and correctly in the two service areas. All medications are prescribed correctly, dated as per policy guidelines and legislative requirements. There were no residents self-administering medications and self-administration policies and procedures are in place if required.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Meal services are prepared on site and served in the respective dining area. The menu has been reviewed by a dietitian. The kitchen has been registered under the new Food Control Plan and a notice of registration certificate was sighted. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. A nutritional profile for residents is developed on admission which identifies dietary requirements, likes and dislikes. The residents' weight is monitored regularly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents over the 24-hour period.</p> <p>The kitchen and pantry were observed to be clean, tidy and well stocked. Labels and dates are on all containers and records of temperature monitoring on food, fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. The residents and family/whanau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The manager and clinical manager reported that all consumers who are declined entry are recorded on the initial contact information form and when a consumer is declined, relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The initial assessments are completed within the required time frame on admission while care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The clinical manager utilises standardised risk assessment tools on admission. In interviews, residents and relatives expressed satisfaction with the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate life style care plans and support care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The documented interventions in support care plans and lifestyle care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies were observed and the staff confirmed they have access to the supplies and products they needed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Activities are appropriate to the needs, age and culture of the residents. The activities coordinator develops an activity planner and daily/weekly activities are posted on the notice boards. Resident's files have a documented activity plan that reflects the residents' preferred activities of choice. Over the course of the audit, residents were observed being actively involved in a variety of activities and residents interviewed expressed satisfaction with the activities in place. Individualised activity plans are reviewed every six months or when there is any significant change in participation and this is conducted in consultation with the clinical manager. Twenty-four-hour activity care plans are developed for each resident. The activities vary from scrabble, bingo, music, van trips, exercises/walking and church services. The activities coordinator reported that they have group activities and engage in one on one activities with some residents. Activities are modified to varying abilities and cognitive impairment. The residents' activities participation log was sighted.</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>Residents' lifestyle care plans and activity plans are evaluated in a comprehensive and timely manner. Reviews are fully documented and include current resident's status, any changes and achievements towards goals. Family/whanau and staff input is sought in all aspects of care and are reviewed/evaluated. Support care plans are developed as per rising need. All care plans sampled are updated and reviewed every six months or as required.</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>There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Residents and family are informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GP.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</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>Policies and procedures for the management of waste and hazardous substances are documented. All hazardous substances are stored safely. This includes chemicals and oxygen cylinders. Domestic waste is removed as per council requirements. Personal protective equipment is available. Staff receive education on the management of waste and hazardous substances and waste management audits are completed.</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 facility was purpose built and remains fit for purpose. There are three wings, two rest home wings (Totara and Rimu) and the secure dementia unit (Kowhai). Internal and external areas are of sufficient size, with wide corridors, hand rails throughout and safe ramps into the garden. Furniture and fittings have been well maintained. Medical equipment is calibrated and electrical testing and tagging has been completed. There is a maintenance schedule and a system for identifying any maintenance requirements as they occur. There is a hazard identification process and a risk, hazard and emergency response plan. Environmental audits are conducted. The current building warrant of fitness is displayed. There is a van for outings. The van is driven by the activities coordinator. There is a documented process regarding transportation for residents. There is a first aid kit in the van.</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 conveniently located communal toilets and showers on each wing. Toilets and showers are well maintained. There are privacy locks on all toilets and showers. Visitors and staff facilities are available. Each resident room has a hand basin and hand washing gel is located throughout the building. Hot water temperatures are monitored.</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>All resident bedrooms are single occupancy. Rooms are decorated with personal possessions and are of sufficient size to enable use of equipment if required. All rooms have external windows and are exposed to natural sunlight.</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>Each wing has its own communal area consisting of a lounge, dining area and kitchenette. Communal areas are open plan and of a sufficient size to accommodate activities. There are large outdoor areas furnished with tables and chairs. All residents have access to the garden, with a secure area for residents from the Kowhai wing.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are designated cleaning and laundry staff. Cleaning and laundry duties are documented. The cleaning trolley is safely stored when not in use and remains within sight of the cleaner when in use. Chemicals are labelled and material data safety sheets were sighted. All laundry is washed on site. The laundry is separated into clean and dirty areas. Industrial washers and dryers are in good working order. Cleaning and laundry staff have received education regarding the use of chemicals which is conducted by the chemical provider. Cleaning and laundry services are monitored through resident satisfaction surveys and internal audits.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an approved fire evacuation plan. The building is divided into fire cells for staged evacuations. Trial evacuations are conducted every six months. There are fire extinguishers throughout the building and emergency evacuation procedures are displayed.</p> <p>There is an emergency and disaster response plan which covers a range of emergencies. There is sufficient equipment and supplies in the event of an emergency or if the mains supply fails. The generator provides back up electricity and there is emergency lighting and power. There is a first aid kit in each wing and all senior staff have completed first aid training. There is a pandemic box. All resident areas have call bells, including toilets and showers. The level of support each resident would need in the event of an emergency is documented in their care plan.</p> <p>External doors and windows are checked each evening and monthly security checklists are completed to ensure the facility remains safe and secure at all times. Residents interviewed confirmed that they felt safe and secure.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>There is natural light and ventilation. Heating is provided through wall radiators. There are no residents who smoke and a designated external area for staff to smoke is well away from resident areas.</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>The rest home provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The clinical manager is the infection control coordinator (ICC) and has access to external specialist advice from the GP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place.</p> <p>The infection control programme is reviewed annually and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate residents with infectious conditions when required. Hand sanitisers and gels are available for staff and visitors to use. Staff interviewed demonstrated an understanding of the infection prevention and control programme. There were no infection outbreaks reported since the last audit.</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>	FA	<p>The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the health and safety meetings and two monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The service has documented policies and procedures in place that reflect current best practice. Staff were observed to be compliant with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were aware of the location of policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included: GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods</p>	FA	<p>The clinical manager is responsible for the surveillance programme. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff. Information is collated monthly. Surveillance is appropriate for the size and nature of the services provided.</p> <p>The infection control surveillance register includes monthly infection logs and antibiotic use. Infections</p>

<p>that have been specified in the infection control programme.</p>		<p>are investigated, and appropriate plans of action were sighted in meeting minutes. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to treat the infection accordingly.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Environmental restraint is in place for the Kowhai wing. There is secure key pad entry and exit. Only residents who have been assessed as having dementia are residing in the Kowhai wing. There were no other restraints or enablers being used at the time of the audit. There are policies and procedures should a restraint or enabler be required. These are in line with the requirements of this standard. All staff receive training on the use of restraints, enablers and behaviours of concern.</p>

## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.