# Okere House Limited - Okere House

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Okere House Limited

**Premises audited:** Okere House

**Services audited:** Dementia care

**Dates of audit:** Start date: 4 October 2017 End date: 5 October 2017

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 13

# 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 |
|  | 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

Okere House provides level three dementia services for up to 25 residents. The service is operated by Okere House Limited and managed by a manager and clinical leader. Families and a general practitioner spoke positively about the care provided.

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

This audit has resulted in no identified areas of improvement being identified.

## 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 Health and Disability Commissioner`s Code of Health and Disability Services Consumers` Rights (the Code) is made available to residents/families/representatives. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a Maori health plan and related policies. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The manger is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

## 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. |

Okere House Limited is the governing body and is responsible for the service provided at this facility. A business and quality and risk management plans are documented and includes the scope, direction, goals, values and mission statement of the organisation. Systems are in place for monitoring the services provided, including regular reporting by the manager to the governing body.

The facility is managed by and experienced and suitably qualified manager. A quality and risk management system is in place which includes an annual calendar of internal audit activity, monitoring of any complaints and incidents, health and safety, infection control, restraint minimisation and resident/representative/family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of any trends and follow-up where necessary. Meeting minutes were reviewed. Adverse events are documented and are seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Any feedback is used to improve services. The hazard register is up to date.

A suite of policies and procedures cover all aspects of service delivery, are current and reviewed regularly.

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

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. There is a roster for afterhours for staff to contact senior personal.

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

## Continuum of service delivery

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| --- | --- | --- |
| 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. |

Access to the service is appropriate and efficiently managed with relevant information provided to the potential resident/family.

Residents` needs are assessed on admission, with reassessment occurring at least six monthly. Care plans/lifestyle plans are individualised, based on a range of information and document any new problems that might arise. The files sampled demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

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

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

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The facility has been purpose built. There are single rooms all of adequate size to provide personal care.

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

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

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

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points are installed in case of fire. Access to an emergency power source is available. A call bell system is in all residents room and service areas. Security is a priority for this secure dementia service and staff are aware of their obligations to promote safety.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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 organisation has implemented policies and procedures that support the minimisation of restraint. There were no enablers or restraints in use at the time of audit. Staff demonstrated knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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| --- | --- | --- |
| 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. |

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. Surveillance data is benchmarked.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | Okere House has developed policies and procedures to meet its obligation in relation to the Code of Health and Disability Services Consumers` Rights (the Code). Staff interviewed understand the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| 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 | Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation`s standard consent form including consent for photographs, sharing of information and outings.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented when relevant in the resident`s record. Staff demonstrated their understanding by being able to explain situations when this may occur as this is a secure dementia service.  Staff were observed to gain consent for day to day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, families are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the advocacy Service are also displayed in the facility, and additional brochures were available at reception. Family/whanau/representatives spoken with were aware of the Advocacy Service, how to access this and their right to have a support person. Staff have received education on advocacy and the code as verified in the t raining records. |
| 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 are assisted to maximise their potential for and to maintain links with family and the community. The activities coordinators take the residents when possible to the shops and to local community parks and reserves and other functions in the community for those that are able. The facility has unrestricted visiting hours and encourages links with family. Family interviewed stated they felt welcome when they visited and comfortable in their dealings with the staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to families/representatives on admission and there is complaints information and forms available at reception.  The complaints register reviewed that two complaints had been received over the past year. The complaints process was followed and complaints closed out appropriately in the required timeframes as specified in the Code. The manager is responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission information provided and discussion with staff. The home has a resident advocate who visits regularly and provides education for staff. The Code is displayed in the entrance to the facility and information on advocacy services and the code is available in pamphlet format. Families/representatives interviewed are aware of the complaints process and advocacy services. |
| 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 | Families confirmed that their relatives receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit (eg, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information at handover or to each other in the care setting. All residents have their own room.  Residents are encouraged to maintain independence and are taken out into the community as part of the activities programme or outings with family/whanau as able. Each long term care plan reviewed included documentation related to the resident`s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident`s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service`s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff records reviewed and in the training programme sighted. |
| 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 | Staff support the six residents in the service who identify as Maori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day today practice, as in the importance of whanau to residents. There is a current Maori health plan developed with input from cultural advisors. Current access to resources includes contact details of local cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Mori in the facility. There are four staff who identify as Maori. Family/whanau/representatives interviewed reported that staff acknowledge and respect the cultural needs of residents in this secure dementia service. |
| 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 | Family/whanau/representatives interviewed verified that they were consulted with the resident on the resident`s individual culture, values and beliefs on admission and staff respect these. Resident`s personal preferences, required interventions and special needs were included in all care plans reviewed A resident/family satisfaction questionnaire includes evaluation of how well residents ` cultural needs are met and that the individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Families/representatives interviewed stated that the residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner and the resident advocate interviewed also expressed satisfaction with the standard of services provided to residents.  The induction process for staff includes education related to professional boundaries and expected behaviours. The two registered nurses interviewed have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation and the individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence based policies, input from specialist services for example community dietitian, mental health services for older persons, wound care specialist and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsible to medical requests.  Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit was the interaction the care staff had with the residents and the sense of total involvement of the activities programme with residents, staff and whanau in this secure dementia service. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Family/whanau/representatives stated they were kept will informed about any changes to their relative`s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents` records reviewed. There was also evidence of family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Interpreter services are able to be accessed via the district health board (DHB) when required. Staff knew how to do so, although reported this rarely is required as all residents are able to speak English. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. The manager provides a monthly report to the owner director. A sample of reports reviewed shows adequate information to monitor performance is reported including any emerging risks or issues.  The service is managed by a manager who holds relevant business healthcare knowledge and has a New Zealand Diploma of Business and has been in the role for over three years. The manager is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a job description and individual employment agreement. The manager interviewed confirms a good understanding of the aged care sector, regulatory and reporting requirements and maintains currency through attending training at the DHB or conferences. The manager is supported by the clinical leader and one other registered nurse. The clinical leader is training to be an internal assessor. Both the clinical leader and the registered nurse are trained interRAI nurses with current competencies.  The service holds contracts for stage three dementia care, respite and younger person disabled (YPD). On the day of the audit there were 2 YPD with dementia, nil respite, and 11 stage three dementia level residents. The total occupancy is 25 beds and the occupancy was 13 residents. |
| 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 | When the manager is absent, an experienced clinical leader carries out all the required duties under delegated authority. The owner/director is contactable if required. Another registered nurse is also available to cover if needed. Staff reported the current arrangements work well. |
| 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 | The organisation has a quality and risk system that reflects the principles of continuous improvement and is understood by staff. This includes management of incidents and accidents, complaints, audit activities, satisfaction surveys, monitoring of outcomes, clinical incidents including any infections.  Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs and related information is reported and discussed at the monthly quality meetings. Minutes reviewed include discussion on pressure injuries, complaints, incidents/events, infections and audit results and activities. Staff reported their involvement in quality and risk activities through the internal audits. Relevant corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvement is occurring. Resident/relative surveys are completed annually and survey outcomes reflected that families are pleased with all services provided for their relatives.  Policies reviewed cover all necessary aspects of the service and contractual requirements and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval distribution and removal of obsolete documents. Staff are updated on any new policies or changes to policies through the staff meetings held monthly.  The manager described the processes of identification, monitoring and reporting of any risks and development of mitigation strategies if needed. Any risks would be discussed with the owner/director. The risk register is reviewed regularly. The manager is aware of the Health and Safety at Work Act (2015) requirements and has implemented the requirements. |
| 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 | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed show they are fully completed. Incidents are investigated, action plans developed and actions followed up in a timely manner. Adverse events data is collated, analysed and reported to the owner/director and to staff at the staff meetings. Meeting minutes reviewed show discussion has occurred regarding any trends identified, action plans and improvements made at the quality meetings held monthly.  Policy and procedures described notification reporting requirements. The manager is well informed on the responsibilities involved. There have been no notifications since the last audit. |
| 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 | Policies and procedures ae in line with good employer practice and relevant legislation, guide human resource management processes. Job descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of records reviewed confirmed the organisation`s policies are being consistently implemented and records are systematically maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from another staff member in the form of a `buddy` system through the initial orientation period. Staff records reviewed show documentation of completed orientation and a performance review completed annually.  Continuing education is planned on an annual basis. Mandatory education requirements are defined and scheduled to occur annually. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements for the provider`s agreement with the DHB. The manager is a qualified assessor and the clinical leader is currently training as an onsite assessor. In addition another staff member a senior care giver is a qualified internal assessor as verified in the staff records reviewed. All care staff have completed the dementia education required. Education records reviewed demonstrated completion of the required training. Staff reported that the annual performance appraisals provided an opportunity to discuss individual training needs. Appraisals were current for all staff. |
| 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 a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The manager adjusts staffing levels to meet the changing needs of residents. The minimum number of staff is provided during the night shift and consists of two care givers. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. The two registered nurses alternate the on call for clinical issues and the manager is contacted for non-clinical requirements as needed. This was further supported by the family/whanau/representatives interviewed. Observation of the roster cycle during the audit confirmed adequate staff cover has been provided. No bureau have been contracted by the manager. At least one staff member on duty has a current first aid certificate. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident`s name, date of birth and National Health Index (NHI) number are used on all resident records reviewed as the unique identifier. All necessary demographic, personal, clinical and health information was fully completed in the residents` records sampled for review. Clinical notes were current and integrated with GP and other health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents` records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| 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 | Residents enter the service when their required dementia level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. The service provides rest home specialist dementia level of care only. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC or GP for residents accessing respite care.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses a transfer form to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed the transfer form and discharge information from the acute care hospital when the resident returned to the service. Family of the resident reported being kept well informed during the transfer of their relative |
| 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. | FA | The medicine management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management was observed on the day of audit. The staff observed demonstrated knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medicines are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medicines against the prescription. All medicines sighted were within current use by dates.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge were recorded daily and were within recommended temperature guidelines. There were no medicines currently stored in the fridge.  There is an electronic medication management system. Best practice prescribing practices were noted and include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review is consistently recorded on the medicine records. The service does not use standing orders.  There are no residents who self-administer medicines and is not appropriate for the dementia specific level of care provided at Okere House. |
| 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 | The food service is provided on site by the kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The staff have regular in-service training on the importance of nutrition and hydration for the residents. The staff have unrestricted access to food and fluids to meet the resident’s nutritional needs 24 hours a day.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded. The service has developed a draft food safety plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.  Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were observed to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| 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 | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial nursing assessment information is documented using validated nursing assessment tools such as (pain scale, falls risk, skin integrity, nutritional screening, challenging behaviours and depression scale), to identify any deficits and to inform care planning. The interRAI tool is then used for other assessments and re-assessments. The sample of lifestyle plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed, which includes assessments for challenging behaviours. Families interviewed confirmed their involvement in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in lifestyle plans sampled. All files sampled included behaviour management plans.  The lifestyle plans evidenced service integration with progress notes, activities notes, with medical and allied health professionals’ notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Families reported participation in the development and ongoing evaluation of service delivery. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and their plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The staff interviewed verified that medical input is sought in a timely manner and supporting the resident is based on the resident’s individual needs and capabilities. Care staff confirmed that care was provided as outlined in documentation. A range of equipment and resources was available, suited to the dementia specific level of care provided and in accordance with the residents’ needs. |
| 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 | The activities programme is provided seven days a week, by activities coordinators and volunteers that have appropriate experience and knowledge of dementia care. The activities staff are working towards gaining their diversional therapy qualification and have completed specific dementia related training. The activities coordinators have the support of a mentor who is a diversional therapist.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. Each of the files sampled included a 24-hour plan for diversional therapies and behaviour management. The resident’s activity needs are evaluated as part of the formal six-monthly plan review.  Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and family/whānau are involved in evaluating and improving the programme through the multi-disciplinary review process and satisfaction surveys. The families interviewed confirmed they find the programme stimulating and meaningful for their relatives. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents’ needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds and pain management.  When necessary, and for unresolved problems, long term care plans are added to and updated. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a ‘house doctor’, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to oncology and general surgery. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if needed |
| 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 | Documented processes for the management of waste and hazardous substances were in place. The doors to the areas storing chemicals were secured and containers labelled. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provided relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Any related incidents are reported in a timely manner.  There is provision and availability of protective clothing and equipment and staff were observed using this, including gloves and aprons and hats. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness dated expiry 22 June 2018 was displayed at the entrance to the facility.  Appropriate systems are in place to ensure the residents` physical environment and facilities are fit for purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment.  External areas are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe. Families interviewed confirmed they know the processes they should follow if any repairs or maintenance is required. Any requests are appropriately actioned by the maintenance person. |
| 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 are adequate numbers of accessible bathrooms and toilets throughout the facility. Appropriately secured and approved handrails are provided in the toilet/ shower areas, and other equipment/accessories are available to promote resident independence. There are two toilets available for staff and/or visitors. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised in a minimal way due to the nature of this stage three dementia service. There is room to store mobility aids if needed. All rooms have pictures on the walls. |
| 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 | There is one large dining room. Communal areas are available for residents to engage in activities. The dining room and lounge areas are spacious and enable easy access for residents and staff. Residents are able to access their rooms for privacy if required. Furniture is appropriate to the setting and resident needs, It is arranged in a manner which enables residents to mobilise freely. |
| 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 | All laundry is undertaken on site. Resident`s personal clothing is laundered on site or by family members if requested. Families reported the laundry is well managed well and their relatives` clothes are returned in a timely manner. The laundry is managed by a designated staff member who is very experienced working in the laundry and providing this service. The staff member interviewed had a sound knowledge of the laundry processes, dirty /clean flow and handling of soiled linen.  There are two staff who share the cleaning/laundry role seven days a week. Both staff members have received appropriate training. Training records were reviewed. Chemicals were stored in a locked cupboard and were in appropriately labelled containers. Cleaning and laundry processes are closely monitored through the internal auditing system and the contracted company representative from where the chemicals are purchased provides product monitoring and education for the staff. The cleaner`s trolley is stored in the locked cleaner`s cupboard when not in use. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and procedures for emergency planning are developed and implemented. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 12 January 2001. Trial evacuations take place six monthly and a letter is sent to the New Zealand Fire Service. The orientation programme for all new staff includes fire and security training. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones, batteries, torches and a gas barbecue were sighted and meet the requirements for 25 residents. Water storage is available with an emergency water tank at the rear of the property. Emergency lighting is available and a petrol generator all of which are checked six monthly. A larger generator has been arranged with a contracted company in the event of an emergency lasting more than two hours.  There is a nurse call system throughout the facility. Call bell system audits are completed as part of the internal audit schedule.  Appropriate security arrangements are in place. Doors and windows are checked by staff at end of each day. The event of a security breach the police are summoned if required. This is a secure dementia care facility with a locked front door and locked external gate at side of the building which is not normally accessible to residents but is checked on a regular basis by the maintenance manager. The service has four sensor mats with only two in use. The maintenance person ensures they are all in good working order at all times. |
| 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 residents` rooms and communal areas have opening external windows. Electric heating is provided with ceiling heating pads which are centrally controlled. There is a large heat pump situated in the main lounge. Areas were warm and ventilated throughout the audit and families confirmed the facility is maintained at a comfortable temperature. |
| 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 service implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from external specialists. The infection control programme is reviewed annually through an annual report with trend analysis and has goals for the upcoming year.  A registered nurse is the designated infection prevention and control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results are reported monthly to the senior management through the integrated quality meeting.  The infection control manual provides guidance for staff about how long they must be away from work if they have been unwell. Staff interviewed understood these responsibilities. Vaccination is encouraged for staff and residents.  There are family meetings that cover aspects of infection control and if they are unwell, it is recommended that they do not visit the service. During higher risk times of community infections and winter months notices are placed at the door to remind people not to visit if they are unwell, there is sanitising hand gel at the entrance and throughout the service. |
| 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 of the organisation. | FA | The infection prevention and control coordinator has appropriate skills, knowledge and qualifications for the role. They have attended specific education related to infection prevention and control.  Additional support and information is accessed from the infection control team at the DHB and the GP and as required. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections. The coordinator confirmed the availability of resources and external specialists to support the programme and any potential outbreak of an infection. |
| 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 | The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. The policies and procedures are developed by the organisation with advice from external specialists. Policies were last reviewed in 2017 and include appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the infection prevention and control coordinator (RN) and external specialists. The RN attends regular education with external specialist and the DHB to maintain their knowledge of current practice.  Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infectious outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.  Education with residents is generally on a one-to-one basis and has included subjects such as encouraging fluids, reminders about handwashing, advice about remaining in their room if they are unwell. The family meetings are used to remind families and visitors regarding standard precautions. |
| 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 is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs, with short term care plans developed.  Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Where there has been an increase in infections, corrective actions are implemented. There has not been any recorded outbreak of inactions in the data sampled for 2017. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and for their role and responsibilities.  On the day of audit, there were no residents using restraints or enablers, any restraint or enabler use is the least restrictive and used voluntarily. A similar process is followed for the use of enablers as is used for restraints.  The service has previously been temporarily required to use a bed rail on one side of the bed for two residents after these residents had a surgical procedure. The restraint register records that the pre-assessment, risk assessment, consent (from EPOA and GP), implementation, monitoring, review and evaluation processes were followed for these residents.  The alternative options are sensors mats and fall out mats. The layout of the service enables residents to wander freely.  Restraint is used as a last resort when all alternatives have been explored. There is an annual training and competency assessment for restraint minimisation and safe practice. This was evident on review of the restraint approval group minutes, files sampled, and from interview with staff. |

# 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.

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| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.