

Experion Care NZ 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 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:

Legal entity: Experion Care NZ Limited

Premises audited: Okere House

Services audited: Dementia care

Dates of audit: Start date: 17 June 2019 End date: 18 June 2019

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: 23

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Okere House provides dementia level of care for up to 25 residents. The service is owned by Experion Care NZ Limited and is managed by a

facility manager supported by a clinical lead. Families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health

board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews, residents, family, management, staff and a general practitioner.

There is one area requiring improvement identified during this audit relating to food management.

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 and the families of residents at Okere House. Opportunities are provided to discuss the Code, consent and availability of advocacy services at the time of admission and thereafter as required.

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

Care for residents of Okere House who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination. Staff understood and implemented related policies and 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.

Okere House has links with a range of specialist health care providers, which assists in ensuring services provided to residents are of an appropriate standard.

The facility manager is responsible for the management of complaints and a complaints register is maintained. There have been no new

investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services

provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to

improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions

implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service

delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing

training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs

of residents.

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

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The management of Okere House works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident and their family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Verbal handovers and communication sheets guide continuity of care when shifts change.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Registered nurses and senior care staff administer medications, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications.

Safe and appropriate environment

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

Electrical equipment

is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and

provide shade and seating.


Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are

safely stored. Cleaning and laundry are managed by staff onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures

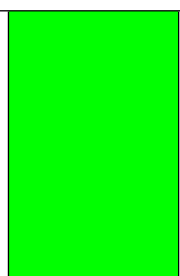
are regularly practised. Families reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers or restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews is documented should it be required. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and appropriately trained infection control co-ordinator, aims to prevent

and manage infections. Specialist infection prevention and control advice is accessed from the district health board, and an external provider.

The programme is reviewed annually.

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

Aged care specific infection surveillance is undertaken, analysed and trended. Results are reported through all levels of the organisation. Follow up action is taken as and when required.

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	1	0	0	0
Criteria	0	93	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Okere House has policies, procedures and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood 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.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>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 for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. All residents have an advanced care statement signed by the family and the general practitioner. Staff demonstrated their understanding by being able to explain situations when this may occur. All files reviewed evidenced residents having an activated enduring</p>

		<p>power of attorney in place.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents' families are given a copy of the Code which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents of Okere House are assisted to maximise their potential for self-help and to maintain links with their family and the community by being supported to attend a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that one complaint has been received since the last audit and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible.</p> <p>The manager is responsible for complaints management and works with the clinical lead to follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Interviews with residents' family members, verified they were made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and ongoing discussion with staff. The Code is displayed in the entrance way of Okere House and in common areas. Brochures on the Code, together with information on advocacy services, how to make a complaint and feedback forms are also on display.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents families confirmed that residents receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff of Okere House understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents have a private room.</p> <p>Residents are assisted to maintain their independence by being supported to participate in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing through previous lifestyle patterns. Each care plan included documentation relating to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood Okere House'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 by staff interviews and training records.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There were four residents and eight staff members at Okere House at the time of audit who identified as Māori. Interviews verify staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers and is present in the two files reviewed of residents who identify as Maori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	FA	<p>Interviews with residents' families, observations and sighted documentation, verified that families were consulted on the resident's individual culture, values and beliefs and that staff respected these.</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire completed late 2017 includes evaluation of how well residents' cultural needs are met. Interviews with family members, family meeting minutes, observations and documentation supported that individual needs are being met. An updated resident/family survey is due to be commenced September 2019.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are 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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The management of Okere House encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care nurse practitioner, wound care specialist, infection control nurse, services for older people, the psycho-geriatrician and mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support to access external and internal education opportunities. A diverse in-service training programme operates at Okere House and ensures staff are well trained to enable effective de-escalation management of behaviours that challenge. An attendance register evidences the uptake of training opportunities by staff is high. RNs have access to ongoing training offered by the Whanganui District Health Board (WDHB). All care staff have attended training on 'walking in another's shoes. All staff attend a yearly compulsory training on minimising the use of restraint. The effectiveness of this training is evidenced by the non-use of restraints at Okere House since mid-2017.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents family members stated they were kept well 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 resident/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.</p> <p>The facility manager always has an open-door policy regarding being available to family members. The office is located off the lounge and the facility manager is always visible. Feedback on family satisfaction or dissatisfaction is openly encouraged.</p> <p>Interpreter services can be accessed via the WDHB. Staff knew how to do so and brochures on the service were easily accessible. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</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>	<p>FA</p>	<p>The strategic and business plans outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans. Monthly reports to the owner provide information to monitor performance including financial performance, emerging risks and issues.</p> <p>The manager is suitably skilled and experienced for the role. has relevant business healthcare knowledge with a New Zealand Diploma of Business and has been in the role for over four years. Responsibilities and accountabilities are defined in a job description and an 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 and industry conferences.</p> <p>The clinical leader and one other registered nurse support the manager. The clinical leader is a trained internal assessor and InterRAI nurse. The registered nurse is currently completing InterRAI training. Both nurses have current competencies.</p> <p>The service holds contracts with the DHB, for stage three dementia care, respite and younger person with a disability (YPD) services. On the day of audit 21 residents were receiving stage three dementia services and two residents were receiving dementia services under the YPD contract. No one was receiving respite care. The service has</p> <p>25 beds.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the facility manager is absent, the clinical lead carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. The service management reflects a resident and family centred approach as indicated in the values of the organisation.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular family satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls, medication errors, behavioural challenges and pressure injuries.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the various team meetings, the quality meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, and in response to incidents and complaints. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction survey was last completed in 2017 prior to the last audit and showed satisfaction with the services provided. An updated survey is reported to be planned for later in 2019.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the InterRai Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice 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. Hard copies of relevant policies and procedures are provided for staff reference.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and there is evidence that requirements are 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>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the owner and staff through the monthly meetings.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health/DHB since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The facility manager is the internal assessor for the programme.</p> <p>All care staff have completed the required dementia care education. The activities coordinator is enrolled and the two new staff are to be enrolled at their three-month review. The clinical lead maintains annual competency requirements to undertake interRAI assessments. The registered nurse has one module to finish to complete InterRAI training. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7).</p> <p>The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN available on call for the home.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents enter Okere House when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager and the clinical leader (CL). The resident and their family are also provided with written information about the service and the admission process.</p> <p>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 demographic details, assessments, an Enduring Power of Attorney (EPOA) an activation of the EPOA and a signed admission agreement in accordance with contractual requirements.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses their own 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. At the time of transition between services, appropriate information, including medication records and the care plan 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 transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good 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.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with regulations. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Vaccines are not stored at the facility.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who self-administer medications at the time of audit.</p> <p>Medication errors are reported to the RN and CL and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p>

		Standing orders are not used.
<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>	PA Low	<p>The food service is provided on site by one of two cooks 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 21-6-2018. Recommendations made at that time have been implemented.</p> <p>A food control plan is verified by email as having been registered through Care Association of New Zealand (CANZ), however there is no documentation verifying Okere House has a registered food control plan with the Ministry of Primary Industries (MPI). An email is sighted that confirms a verification audit of the food control plan is booked to take place 5 July 2019. A phone call to MPI on the day of audit, could not verify registration and will take 20 days.</p> <p>Aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines; however, a cleaning schedule has not been completed as per Okere House policy in the past two months. There is no evidence to verify the freezer has been defrosted since 9th April 2019, and there is an ice build-up. There is no process in place to monitor temperatures and time frames of food being cooked in the morning and cooled to use at the evening meal. Cooked food temperatures including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>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. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by family interviews, stability of resident's weights, resident and family meeting minutes and observation of residents eating habits. Any areas of dissatisfaction evidenced by residents not eating their meals were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</p> <p>Staff have access to food items at any time of the day to satisfy residents nutritional desires or needs.</p>
Standard 1.3.2: Declining	FA	If a referral is received, but the prospective resident does not meet the entry criteria of Okere House, or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and

<p>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>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. Examples of this occurring were discussed with the facility manager, when a change in a resident's need level necessitated the residents transfer to a new placement. There is a clause in the access agreement related to when a resident's placement can be terminated.</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>On admission residents of Okere House are initially assessed using a range nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, behaviour assessments and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation and observation verifies the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents have current interRAI assessments completed by one trained interRAI assessor on site (one has completed 95% of the training and waiting results). InterRAI assessments are used to inform the care plan.</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>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 are reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents families reported participation in the development and ongoing evaluation of care plans.</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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</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>The activities programme is provided by two recreation officers, who are supported and mentored by a diversional therapist.</p> <p>A social assessment and history are undertaken on admission by the diversional therapist 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. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review. All files reviewed had a twenty-four-hour activity plan in place to address resident twenty-four-hour activity needs</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. The diversional therapist reviews the activities plan. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included an exercise programme, Tai Chi, visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the minuted residents/family meetings every two months. Minutes indicate resident's family members' input is sought and responded to. Resident family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents families interviewed confirmed they find the programme meets their needs. Residents observed at audit were seen to be interacting and involved in a wide range of activities.</p> <p>Family get together days are held every six weeks, with Okere House inviting families in to spend the day and have a meal.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. The RN documents evaluations. Where progress is</p>

and timely manner.		different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and 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 main medical provider, 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 older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family 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 the circumstances dictate.
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	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated maintenance person who ensures minimum quantities of hazardous substances are held onsite. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals were stored, and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit	FA	A current building warrant of fitness (expiry date 22 June 2019) is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit

<p>for their purpose.</p>		<p>for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is undertaken annually as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Laundry and cleaning processes are monitored and meet required standards.</p> <p>Efforts are made to ensure the environment is hazard free, that residents are safe, and independence is promoted. External areas are safely maintained and were appropriate to the resident group and setting. The walking paths are designed to encourage purposeful walking around the garden. A safe, sheltered external area is provided for smokers.</p> <p>Staff, family members/EPOA confirmed they knew the processes they should follow if any repairs or maintenance was required, that any requests are appropriately actioned and that they were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of shared accessible bathroom and toilet facilities throughout the facility. This includes six toilets and three showers. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence</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>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheelchairs and mobility scooters. Staff and family reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe,</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in social activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>

adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		
<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>Laundry is undertaken on site in a dedicated laundry and by family members if requested. Care staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Family interviewed reported the laundry is managed well and the residents' clothes are returned in a timely manner.</p> <p>There is a small experienced designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through monthly meetings, regular feedback from staff and the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Emergency planning considers the unique needs of people with dementia. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described 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 in 2001. The facility has sprinklers, fire hoses and extinguishers throughout. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in April this year (2019). The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the residents. Water storage tanks are located around the complex, and there is a generator available if required. Emergency lighting is regularly tested. Call bells and sensor mats alert staff to residents requiring assistance. Call system audits are completed on a regular basis and families reported staff respond promptly to call bells.</p>

		Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and staff do security checks at night.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and communal areas have doors that open onto secure outside garden areas. Heating is provided by heat pads in the ceiling in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to</p>	FA	<p>The infection prevention and control coordinator have appropriate skills, knowledge and qualifications for the role. They have attended specific education related to infection prevention and control.</p> <p>Additional support and information are accessed from the infection control team at the DHB and the</p>

implement the infection control programme and meet the needs of the organisation.		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.
<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 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 November 2018 and include appropriate referencing.</p> <p>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.</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>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.</p> <p>Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.</p> <p>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.</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>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 infection control coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early</p>

<p>that have been specified in the infection control programme.</p>		<p>intervention occurs, with short term care plans developed.</p> <p>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 infections in the data sampled since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures around restraint and enablers 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 at Okere House and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>Okere House is committed to being restraint free, and on the day of audit there were no residents using restraint or enablers.</p> <p>Interviews verify restraint is used as a last resort when all alternatives have been explored.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group made up of the restraint co-ordinator, FM, CL and the GP, are responsible for the approval of the use of restraints and the restraint processes as defined in policy. It was evident from review of quality meeting minutes, review of residents' files and interview with the coordinator that there are clear lines of accountability if restraint is to be considered.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making, is required by the organisation's policies and procedures.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>The temperatures of cooked foods are recorded daily, as are fridge freezer temperatures. Records evidence the required temperatures are maintained. All decanted items have ‘use by dates’ recorded. Food in the refrigerator is covered and dated.</p> <p>The cleaning schedule for the kitchens cleaning regime has not been completed to verify all the required processes have been attended to in the last two months. The freezer is not evidenced to have been defrosted monthly as required, since April 2019. There is no process in place to monitor the temperatures and timeframes of food that is kept for use later in the day. No evidence is sighted to verify pest management is being monitored. There is no verification that a food control plan for Okere House has been registered. All these areas were attended to by the manager on the day of audit.</p>	Attention is required to several kitchen practices to ensure they comply with recommended guidelines and legislative requirements.	<p>Provide evidence all food management practices are being monitored. Provide evidence a food control plan has been registered with the Ministry of Primary Industries.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.