

Experion Care NZ Limited - Okere House

Introduction

This report records the results of a Surveillance 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: 30 July 2021 End date: 30 July 2021

Proposed changes to current services (if any): An increase in bed number capacity from 25 beds to 26 beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 25

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Okere House provides rest home level care for up to 26 residents with dementia. Okere House is owned by Experion Care NZ Limited and managed by a clinical nurse manager, who is supported by a registered nurse, and a clinical nurse consultant. (The clinical nurse consultant was the previous general manager). Families spoke positively about the care provided.

This unannounced surveillance 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 nurse practitioner.

The service has addressed one previous audit shortfall relating to food management, a food control plan is in place. Further improvements continue around focus on client centred care. The service has increased the bed capacity from 25 to 26 beds. This audit identified shortfalls around quality, risk, and service provision.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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There is evidence of open disclosure, interviews with relatives demonstrated satisfaction in communication regarding their family member receiving care. Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The clinical nurse manager is responsible for the management of complaints. A complaints register is maintained. There have been six complaints since the previous audit. This has included one report to the district health board; and one report to the National Health and Disability Advocacy service, which was forwarded to the district health board. These complaints have been investigated and there was evidence that they had been resolved. Residents, relatives, and staff are aware of the complaints process.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Okere House has a current business plan that includes specific goals for 2021. Services are planned, coordinated and are appropriate to the needs of the residents. The clinical nurse manager is experienced and suitably qualified and is responsible for the day-to-day operations. The clinical nurse manager has the support of a nurse consultant and reports to the owner.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and improvements. Staff are involved in the quality improvement process, 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.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Registered nursing cover is provided seven days a week. Residents and relatives reported that staffing levels are adequate to meet the needs of the residents.

The service identifies training needs, plans the training, and ensures delivery of training. Staff training and support includes ensuring service delivery is provided in a safe manner and there is regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Residents' of Okere House have their needs assessed on admission by the multidisciplinary team within the required timeframes. Shift handovers and communication sheets guide continuity of care.

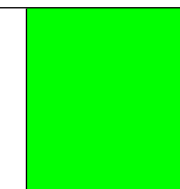
Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified. Residents' family members when interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is provided by two activity co-ordinators. The programme runs seven days a week 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. Medications are administered by registered nurses and senior care staff.

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. The kitchen was well organised, clean and meets food safety standards. Residents and their family members verified overall satisfaction with meals.

Safe and appropriate environment

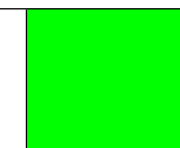
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group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

Staff are trained in emergency procedures, use of emergency equipment, and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

A request to Increase bed numbers from 25 to 26 is approved by the audit team.

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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An assessment, approval and monitoring process with regular reviews is in place if required. Staff demonstrated knowledge and understanding of the restraint and enabler processes. There were no restraints or enablers in use on the day of the audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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There is an infection prevention and control programme in place. The service had implemented infection control activities in response to the Covid 19 pandemic. The infection control co-ordinator is led by the clinical nurse manager who is experienced and appropriately trained. Specialist infection prevention and control advice is accessed from the district health board, and an external provider. The infection prevention programme is reviewed annually. Staff demonstrated good principles and practice around infection control, guided by relevant policies and supported with regular education. Infection surveillance is undertaken, analysed, and reviewed. Infections are monitored and evaluated for trends and discussed at staff meetings.

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	15	0	1	1	0	0
Criteria	0	44	0	1	1	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 1.1.13: 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 process meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families and those family members interviewed knew how to make a complaint should they need to.</p> <p>The complaints register reviewed showed that six complaints had been received since the last audit. Two of these complaints had been received from external sources. There was evidence that all complaints had been investigated, documented, completed, and closed out. The service had implemented improvements where opportunities for improvement were identified. Each complaint was comprehensively reviewed as part of the audit process.</p> <p>The clinical nurse manager is responsible for complaints management and works with the nurse consultant to follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Residents' family members stated they were informed about any changes to their relative's status, and advised in a timely manner about any incidents, accidents, and outcomes of any 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>consumers and provide an environment conducive to effective communication.</p>		<p>The clinical nurse manager works to ensure effective communication with family members. Feedback from residents and their families is openly encouraged. Interpreter services can be accessed via the WDHB.</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 service has a strategic business plan and a quality and risk management plan in place, and goals have been reviewed. Monthly reports to the owner provide information to monitor performance including financial performance, emerging risks, and issues.</p> <p>The clinical nurse manager is a registered nurse with aged care experience and is supported by a clinical nurse consultant . The clinical nurse consultant was previously the general manager; and had resigned from the general manager role in July 2021. (The clinical nurse consultant also attended the audit.) The clinical nurse manager interviewed confirmed a good understanding of regulatory and reporting requirements and maintains currency through attending DHB and industry training.</p> <p>The clinical nurse manager reports to the owner. The clinical nurse manager has the support of one other registered nurse. The clinical nurse manager is InterRAI trained. 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 a day care contract. On the day of audit 25 residents were receiving stage three dementia services. There were no residents receiving dementia services under the YPD contract, and no residents receiving respite care. The service has the capacity for 26 beds.</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</p>	<p>PA Moderate</p>	<p>The clinical nurse manager facilitates the quality programme and ensures the internal audit schedules are implemented. The service ensures that corrective actions are developed, implemented, and signed off when shortfalls are identified.</p> <p>Quality improvement processes capture and manage non-compliances. These include internal audits, hazard and risk management, incident and accidents, behavioural concerns, infection control data collection and complaints management. All quality improvement data is discussed formally at staff meetings, and on a day-to-day basis during handovers. This was confirmed in interview with the caregivers.</p> <p>Meeting minutes reviewed confirmed review and analysis of quality indicators are undertaken. Staff reported their involvement in quality and risk management activities through audit activities, in response to incidents, complaints and through continuous improvement initiatives. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>A resident / family satisfaction survey has been sent to family and residents. Feedback from resident / family</p>

<p>principles.</p>		<p>meetings showed positive feedback with the services provided. The family and residents interviewed expressed satisfaction with all aspects of the service.</p> <p>There is a current risk management plan in place. Hazards are identified, managed, and documented. The clinical nurse manager is the designated health and safety officer. Health and safety issues are discussed at every staff meeting with action plans documented to address issues raised.</p> <p>Staff identified quality and risk concerns during the audit. Staff reported that room temperatures can be very cold at times. Staff reported that call bells are not available in the lounge, activities, and dining area, if staff need assistance. Staff reported that sensor mats are not easily connectable to the system in place, and there is no emergency call bell available. Staff reported that many of the beds are old, and these older beds are difficult to manoeuvre and provide care for residents.</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>Review of incident data demonstrated NOK notifications or the reason for not notifying was documented. Neurological observations had been completed for all unwitnessed falls, with appropriate RN follow-up, and opportunities to minimise risks were reviewed. Accidents and incidents are analysed monthly. This information is discussed at staff meetings. Adverse event data is collated, analysed, and reported to staff through the monthly meetings, and to the owner.</p> <p>The clinical nurse manager described essential notification reporting requirements. Ten section 31 reports to the Ministry of Health had been made since the previous audit, these were reviewed. All section 31 incidents had been addressed and closed out. Incident reports were reviewed and there was documented evidence that relatives had been notified of the incident or the reason the relative had not been contacted was documented. Staff interviewed were aware of their responsibility to notify next of kin of any accident/incident and ensure full and frank open disclosure occurs.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with</p>	<p>FA</p>	<p>Five staff files were sampled, the clinical nurse manager, registered nurse, cook, caregiver and a cleaner. File reviews demonstrated appropriate employment practices and documentation. Current annual practicing certificates were accessible. The recruitment process includes referee checks, police vetting, validation of qualifications and practising certificates (APCs), where required. Staff files reviewed demonstrated that the orientation package was completed in staff files sampled.</p> <p>There is an annual training plan in place, including mandatory training requirements. Care staff have either completed or are undertaking a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Care staff have completed dementia care education. Files</p>

<p>good employment practice and meet the requirements of legislation.</p>		<p>sampled contained evidence of training and where staff were due for appraisals, these had been completed.</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>The facility has a rationale for staffing the service. Staffing rosters were sighted and there was evidence that staff are replaced where there are absences. Staff on duty match needs of different shifts and needs of residents.</p> <p>An after-hours on call roster is in place. Staff reported they are able to access advice and support when needed. Care staff reported there were adequate staff available to complete the work allocated to them. A 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 support available on call for the home. The clinical nurse manager and the registered nurse share on call. Staff, residents, and relatives interviewed confirmed that staffing levels are adequate.</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 member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All senior care staff who administer medicines have had a review within the last year, for their competency to perform the function they manage. Both RNs are deemed competent.</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 requirements. 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.</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>Medication errors are reported to the RN and Clinical Nurse Manager (CNM) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis</p>

		<p>of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Okere House</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a cook. The menu follows summer and winter patterns however has not been reviewed by a qualified dietitian since June 2018, to verify the menu is in line with recognised nutritional guidelines for the older adult (refer criterion 1.3.3.3).</p> <p>There is an up-to-date food control plan in place that expires August-2021. A verification audit of the food control plan, is sighted as booked for 18 August 2021</p> <p>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 as part of the plan. The cook has 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 weight records, observation at mealtime, residents' family member interviews, and resident/family meeting minutes. 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. Residents have access to food anytime night and day.</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>	FA	<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, including continence, wound care, post fall assessments and management and behaviour management was evident in all areas of service provision. Wound assessment, planning and monitoring is sighted for all wounds, however during the week of audit, attention to three wounds has not been provided as documented (refer criterion 1.3.3.3). Prompt request for specialist assistance was sought if needed i.e., wound care nurse, speech language therapist, mental health, and addiction services. The NP 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.</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 seven days a week, by two activities coordinators, with oversight from the diversional therapist at Alzheimer's Wanganui, who used to work at Okere House.</p> <p>A social assessment and history are 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. The resident's activity needs are evaluated regularly and as part of the formal three/six monthly care plan review. There is a 24-hour care plan in place in residents' files, that addresses residents' 24-hour activities needs</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included body exercises, 'Let's Dance' sessions, van outings to local places of interest, visiting entertainers, bowls, gardening, quiz sessions and daily news updates. The activities programme is discussed at the residents and family members meeting. Minutes indicated that input into activities at Okere House by residents and their family members is sought and responded to. Meeting minutes, observations and interviews with residents and their family members verified residents enjoyed the programme and find the programme meets their needs.</p> <p>Several volunteers come in and assist with the activities programme at Okere House. Volunteers sign a confidentiality agreement to ensure residents privacy needs are maintained.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>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>Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples are sighted of short-term care plans being implemented and reviewed for any new problems that occur i.e., infections, pain, weight loss, medication changes and progress evaluated as clinically indicated. Wound care plans were evaluated each time the dressing was changed. Behaviour management plans were reviewed after each challenging event or when there was a change i.e., the evaluation of whether a resident needs to wear a tracking device as no longer attempts to abscond. Families/whānau of residents when interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 10-6-2022) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The environment was hazard free and resident safety was promoted.</p>

<p>appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>External areas are safely maintained and were appropriate to the resident group/s and setting.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Residents' family members were happy with the environment.</p> <p>The provider has requested an approval to increase the certified beds from 25 to 26. A room, previously used as a whanau room has been converted into a bedroom. The room provides adequate space for the resident to move around. The room contains a hand basin with hot and cold running water. There are adequate and accessible toilets/showers conveniently located in proximity. Fixtures, fittings, and wall surfaces in the room can be easily cleaned. There is an external window that provides natural light.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There has been no alteration to the building structure since the last audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance and monitoring is integral to the infection control programme. The clinical nurse manager is the infection control coordinator.</p> <p>Surveillance includes infections of the respiratory tract, skin tear infection, skin infections, lower respiratory infections, urinary tract infections, gastro-intestinal, eye infections, multi resistant organisms, and any staff workplace acquired infection. The infection control coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, and short-term care plans are developed. Monthly surveillance data is collated and analysed to identify 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 had not been any recorded outbreak of infections in the data sampled since the last audit; however, there was an outbreak of diarrhoea that occurred on the day of the audit. Four residents were affected. The symptoms and procedures in place for residents were documented, and notifications to Public Health were made in a timely manner. Staff were updated at handover regarding the procedures in place and signage was in place for visitors to the facility. There were effective processes in place to manage the outbreak.</p>

		<p>There is close liaison with the nurse practitioner, GPs and the laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>The service has implemented a policy and procedure for the Covid 19 pandemic. The service had preventive procedures in place for the Covid 19 pandemic.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Okere House has documented systems in place to ensure the use of restraint is actively minimised and to ensure that the service is restraint free. There were no restraints or enablers in use on the day of the audit. Policies and procedures include definition of restraint 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 role and responsibilities. Interviews verify that restraint is not used; staff understand what constitutes restraint.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service</p>	<p>PA</p> <p>Moderate</p>	<p>The service has a risk management process in place and there is evidence that family/whanau are advised of any actual or potential risks. Staff reported that room temperatures can be very cold at times. Staff reported concerns that call bells are not available in the lounge, activities, and dining area, if staff need assistance. Staff reported that sensor mats are not easily connectable to the system in place, and there is no emergency call bell available. Staff reported that many of the beds are old, and these older beds are difficult to manoeuvre and provide care for residents</p>	<p>Staff identified quality and risk concerns during the audit. Staff reported that room temperatures can be very cold at times. Staff reported that call bells are not available in the lounge, activities, and dining area, if staff need assistance. Staff reported that sensor mats are not easily connectable to the system in place, and there is no emergency call bell available. Staff reported that many of the beds are old, and these older beds are difficult to manoeuvre and provide care for</p>	<p>The service provider provides a plan to address the following concerns: - reported cold room temperatures; lack of call bell accessibility in the lounge, activities, and dining area if staff need assistance; the concern regarding sensor mats not being easily connectable to the system in place; the lack of emergency call bell; and the concerns regarding the difficulties with older beds being difficult to manoeuvre</p>

<p>provision is developed and implemented.</p>			<p>residents</p>	<p>and provide care for residents.</p> <p>90 days</p>
<p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>Three of five files reviewed, had not had the interRAI assessment or the long-term care plans reviewed within the last six months. There is at present, only one interRAI trained RN at Okere, while the other RN is in the process of completing it. Although interRAI assessments have not been updated, the clinical assessments have been, and verify stability in resident status. When any change in care is required, comprehensive use of short-term care plans is occurring. A review of the wound management folder has found all wounds had assessments and management plans that had been attended to consistently, however over the last week three dressings were not attended to on the day requested, as the RN was on leave. A review of the menu by the dietician to verify the menu meets the nutritional needs of the older adult has not been undertaken since June 2018.</p>	<p>InterRAI assessments, updating of long term care plans, wound dressings and a review of the menu are not always being attended to within the required timeframes that safely meets the needs of the resident.</p>	<p>Provide evidence all aspects of service provision are provided within the required timeframes.</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.