

# The O'Conor Institute Trust Board

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## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	The O'Conor Institute Trust Board
<b>Premises audited:</b>	The O'Conor Memorial Home
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 28 July 2015    End date: 29 July 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	48

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
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

The O’Conor Memorial Home is situated in Westport on the South Island’s west coast. The facility is owned by The O’Conor Institute Trust Board and provides rest home, hospital and dementia services in 53 beds. On the days of the certification audit there were 22 hospital care residents, 17 rest home care residents and 10 residents in the dementia wing. There have been no changes to the ownership or the facility since the previous audit.

This audit against the Health and Disability Services Standards included the sampling of residents’ files, interviews with residents, family and staff, and observing the environment. Sampling included an in-depth focus on the care of three permanent residents. Staff files were reviewed to demonstrate their competency and confirm training and qualifications. Information gathered was used to determine the effectiveness of care services and the systems.

There is a strong focus on residents’ needs with increased staffing levels within the dementia wing demonstrating an area of continuous improvement. One area requires improvement relating to staff appraisals and on-going training for kitchen staff.

## 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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The admission process for residents into the facility is planned and timely. Consent forms are provided prior to admission to ensure residents and families have time to consult with others and are fully informed.

During the audit, staff were observed to respect residents' rights during service delivery, allowing for personal choices, acknowledging and supporting cultural, spiritual, emotional, individual rights and beliefs and encouraging independence.

Residents and family members interviewed reported that staff were respectful of their needs, that communication was consistent and appropriate and they were given time for discussions to take place with staff and family. They have a clear understanding of their rights and the facility's processes if these are not met.

Information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, was on display at the entrance to the facility and is available in admission packs and on request.

## 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 low risk.
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The O'Conor Memorial Home has a trust and governing board made up of people who are well known locally and those with business acumen to assist the organisation. There is a vision and mission statement available to staff, residents and their family and this is reviewed with the strategic plan on an annual basis by the governing board. The organisation has a general manager who is appropriately qualified for the role and a clinical manager who is a registered nurse (RN).

A quality manager oversees the quality improvement plan, with registered nurses taking on roles such as infection control and restraint coordinator. Appropriate audits and monitoring is occurring and corrective actions are being undertaken where required. Elements of the quality process are reviewed at the quality assurance committee. Separate health and safety, infection control and restraint minimisation committees meet and report to the quality assurance committee. Staff are informed of quality activities at their monthly staff meetings.

Policies and procedures are available and cover all areas of practice and meet contractual requirements. These are current and there is a process to ensure review.

Human resources processes are in place, including ensuring appropriate qualifications on employment. Induction occurs and a training calendar is developed on an annual basis. An area for improvement relates to the need for all staff to have annual appraisals and kitchen staff to complete training. Staff were being supported to undertake a range of external and internal training opportunities with monthly education sessions and competency reviews.

The general manager oversees the staff rosters and has increased staffing levels in the dementia wing above recommended levels demonstrating continuous improvement.

Residents' information is integrated into one file which is current, secure and individualised. All records reviewed were dated, signed and the designation of the service provider included.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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An information package details processes for admission to O'Connor Memorial Home. This information explains the need for all residents to be assessed prior to admission.

This facility has commenced implementing the interRAI assessment programme. The registered nurse (RN) completes the assessment, from which an individualised, detailed care plan is developed. Regular review occurs to reflect the resident's assessed needs. There has been a comprehensive implementation and review of assessment, care planning and evaluation process with input from residents, families, allied health professionals and the wider community.

Short term care plans are developed when issues arise within the review time frame. Staff were observed providing services in a respectful and dignified manner, reflecting the care plan content. This was also confirmed in resident and family interviews.

The general practitioner (GP) was interviewed during the audit and confirmed the facility provides a high level of care, and assessments and service delivery are appropriate, timely and in line with treatment recommendations.

An activities programme is managed and implemented by two diversional therapists (DTs), providing a variety of group and individual activities to meet the interests of the dementia, hospital and rest home care residents.

A blister pack medication system is implemented by registered nurses (RNs) and care staff assessed as competent to do so who follow the GP's prescription record. The process was observed on the day of the audit demonstrating safe practice occurs. Policies and procedures, storage and reconciliation of medicines meet legislation and guidelines. There is oversight of medication management from an external pharmacist to ensure packs are updated as soon as changes occur.

A dietary profile is completed for each resident on admission and any special dietary needs are met. The kitchen service is managed from within the facility. A nutritional review of the menu occurred in 2015 and recommendations have been implemented.

Personal likes and dislikes are catered for and special events are celebrated. Appropriate monitoring of food transportation and preparation is occurring. All stored food is dated to ensure stock rotation occurs.

## 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 has a current building warrant of fitness, fire service approved evacuation plan and regular fire drills are occurring. All building plant and equipment are regularly tested.

The organisation has a new hospital and dementia wing with the rest home wing in the refurbished older building. All rooms have outside windows and heating which can be individualised. Call bells are available in all resident care areas. There are internal and external communal areas for residents to use and the internal areas were observed as being well utilised.

Appropriate policies and procedures for the management of waste and hazardous substances are in place and are known to staff.

Cleaning and laundry processes are being undertaken by in-house staff and are monitored through the internal audit process with reports provided to the general manager.

Fire and emergency management systems are in place and the organisation has access to a generator in the event of a power failure. There are adequate provisions of resources for residents and staff in the event of an emergency.

## 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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Restraint minimisation and safe practise policies and procedures are in place. Staff have access to relevant training in de-escalation techniques if required. There are currently only enablers in place at O’Conor Memorial Home.

## 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 a documented infection prevention and control (IPC) programme which contains all requirements of the standards. Policies and procedures guide staff in all areas of infection prevention and control practice. The clinical manager is supported by the general manager, quality coordinator and two infection control registered nurses, who are trained in infection prevention and control practices. These five staff form the infection control (IPC) committee, reporting to the quarterly infection control committee meeting, the bi-monthly team leaders meeting and monthly staff meeting. The O’Connor Memorial Home board are informed when changes are required to infection control policies and procedures and surveillance practices, and amendments are then approved by the board.

The IPC team are able to gain advice from a variety of external sources if required and maintain close links to an external specialist infection control organisation in Christchurch. The GP is also consulted regarding individual resident’s infections.



Surveillance of infections is occurring and IPC data is collated and analysed with the aim of minimising infections.

All staff receive IPC education on induction and orientation and at least annually. Residents and family/whanau are educated in IPC practices as required for specific practices and when visiting the facility.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	43	0	1	0	0	0
<b>Criteria</b>	1	91	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Interviews with residents and family (two dementia residents and three family members, three hospital residents and four family members, and three rest home care residents and four family members) and a review of records (two dementia, four hospital and three rest home care) and observation during the audit verified that staff, in dementia, hospital and rest home care areas, have knowledge and understanding of consumer rights and integrate them into every day practice. Records reviewed confirmed staff training occurs initially during orientation and then annually.</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>Informed consent policy and procedures are outlined and are reflected in documentation reviewed. These included signed admission agreements and advance directives, written consents for influenza vaccination (including Power of Attorney signatures prior to vaccination for those residents with dementia), transport, outings, photographs, names on doors and care provision.</p> <p>Staff during interview demonstrated knowledge of informed consent</p>

		practices. Residents and family confirmed and provided examples that staff gain consent on a daily basis.
<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	There are policies and procedures that include the right of residents to have an advocate or support person of their choice. Residents and family/whanau interviewed confirmed that family/whanau and support persons are included in discussions relating to care provision. Staff interviewed were aware of the resident's rights to have a support person of their choice at any time.
<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>All residents and family/whanau interviewed verify that family and visitors of their choice are able to visit at any time and there are no restrictions.</p> <p>External community links are encouraged and enabled to continue, with examples of this provided. Care plans, activities plans and progress notes reviewed confirmed regular outings, activities and appointments where the facility's own transport can be organised to enable attendance.</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	The facility's complaints policy was reviewed and meets right 10 of the Code. Staff during interview demonstrated awareness of how to assist residents/family members if they wish to make a complaint. Family and residents during interview verify they are aware of the complaints process. Complaints are on all meeting agendas. There have been three complaints reported in 2015 and all have been resolved. This was confirmed in the complaints log.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	Residents and family, in dementia, hospital and rest home care, confirmed that they are provided with information regarding the Code of Health and Disability Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service. They verify that explanations regarding their rights occur initially and on an

		<p>ongoing basis if they have any concerns. They are aware an advocate can be appointed if required. None of those interviewed have required the service.</p> <p>Consumer rights posters, consumer rights brochures and information on the Advocacy Service were available at the entrance to the facility, and include information on providing feedback, complaints and compliments.</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>Care plan documents reviewed, in dementia, hospital and rest home care, include preserving independence, values, beliefs and cultural, social, and/or ethnic needs of residents, with further examples observed and provided during interviews with staff.</p> <p>Residents and their family members interviewed have not been subject to, or witnessed, any signs of abuse or neglect. Those interviewed maintain all staff show respect at all times by knocking before entering rooms, ensuring conversations are private, respecting and understanding the individual residents values and beliefs and maintaining independence. These practices were observed during the audit and confirmed in the review of residents' files.</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>Policies on cultural safety and Maori health provide guidelines for the provision of culturally safe services for Maori residents. There is ongoing education in line with the Treaty of Waitangi expectations for staff. For the one Maori resident, the initial assessment identifies the person's needs and an appropriate care plan has been developed in consultation with the resident and whanau and regularly re-evaluated to ensure it meets the resident's required goals and outcomes. The care plan document reviewed and interviews with staff, the resident and whanau confirmed this. Staff include the 'Whare tapa wha' model of health, the spiritual, mental, physical and extended family needs when planning and delivering care.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Alongside the policy and procedures to address the needs of Maori residents in the cultural safety policy, there is a section on cultural needs of all persons within the facility. Residents and family members interviewed verify that the facility continually ensures their individual values and beliefs are met. Examples are provided that demonstrate that staff ensure residents receive services that respect their individual values and beliefs. This was also observed during the audit.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Policy documents reviewed, including the elder abuse and neglect prevention policy, include guidelines to ensure residents are free from any discrimination, coercion, and harassment, sexual, financial, or other exploitation. Staff interviewed demonstrated an awareness of the resident's rights in relation to these areas. Residents and family interviewed verified there have been no issues relating to coercion or exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Induction and orientation for staff aligns to best practice processes. Records reviewed and interviews with staff verified that in service education and ongoing professional development is provided and supported by the organisation. Policies and procedures are current and reflect best practice guidelines. The facility has commenced the interRAI assessment programme for all residents.</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>The facility's Open Disclosure policy describes key principles and explains expectations for the service. Residents and family members interviewed confirmed that communication is appropriate and delivered in a manner the resident and family can understand. Staff were observed taking time to ensure when communicating with residents that they are understood and residents have time to answer.</p> <p>The facility's clinical manager has verified the facility has not needed to access interpreter services, although she could explain the processes in place should these be required.</p>

<p><b>Standard 1.2.1: Governance</b></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 plan 2014-2015 covers all areas relating to service delivery and on-going proposed development of the facility. There are clearly defined values and a mission statement to support these.</p> <p>The mission statement is to 'provide high quality care in a holey and safe environment that acknowledges and respects the unique identity of each resident'. Five key statements identify how this will be met. O'Conor Memorial Home details 11 bullet point objectives and the facility's strategies to ensure these will be met. There is evidence that the facility actively encourages decision making through resident and family feedback.</p> <p>The general manager and the board chairman during interview confirmed their commitment to the community of Westport and the residents at O'Conor Memorial Home as the centre of their forward planning.</p> <p>The general manager has been in place for over six years and is suitably qualified and experienced. She is a registered nurse, and has relevant graduate and post-graduate qualifications. The general manager is supported in her role by a quality manager and a recently appointed clinical manager. Both are suitably qualified for their role.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The general manager informed that the clinical manager and the quality manager provide cover during any absence. Both are suitably qualified to perform the role, and are supported in professional development opportunities.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A quality and risk management system is documented and regularly reviewed as part of the on-going quality process with objectives and a strategy to meet each of these. The quality manager during interview described how quality and risk management related processes were undertaken each month. This was evident in the minutes of the monthly staff meetings and quarterly infection control, health and</p>

		<p>safety, quality improvement meetings when different aspects of the system are discussed and also included in the manager's reports for the Trust Board. There is then a process to ensure all staff are informed.</p> <p>Current and research based policies and procedures are in place to guide the management and service delivery processes at O'Conor Memorial Home. There is a system in place for the control and review of documents.</p> <p>Infection surveillance, health and safety, reportable events, restraint, education and training, complaints, internal audit results, quality improvements and service delivery requirements (for example interRAI) are agenda items discussed at the monthly staff meetings, and quality improvement meetings. Infection surveillance, health and safety and restraint minimisation are separate meetings with minutes demonstrating that these are discussed in depth. Residents' meetings, newsletters and resident and family surveys provide additional feedback and information processes.</p> <p>A corrective action plan is put in place for all areas that fall short of desired outcomes, with actions and timeframes to ensure these are met. All those reviewed have been closed out.</p> <p>A detailed risk management plan describes how actual and potential risks are to be managed. This is noted to be added to at any time an issue may arise, including for alterations to the outside environment during the recent floods.</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>The general manager described examples of essential notification reporting, including responsibilities to the organisation's Trust Board, the local district health board, the Ministry of Health and other government departments.</p> <p>A reportable event system is described in policy documentation and is being implemented accordingly. Accidents/incidents are reported on a form and the incident is followed up by either the general manager or the clinical manager, before being discussed at the staff meetings. Such events were traced for two residents and each showed full</p>

		<p>responses with follow up by the general manager, the inclusion of open disclosure, identification of influencing factors, actions taken and the medical follow up for one.</p> <p>The quality manager analyses reportable events and reported that to date, trends have only been identifiable at the individual level, although staff have been reminded of actions to mitigate any identified risks, as evidenced in staff meeting records.</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>	PA Low	<p>Verification of professional qualifications and annual practising certificates were sighted for the pharmacist, GPs, the podiatrist, the registered nurses and the general manager. In staff files reviewed police checks and reference checks have been completed. Codes of Conduct and employment contracts have been signed. The facility's policy is for performance appraisals to be completed for all care staff two yearly which does not meet contractual requirements.</p> <p>Records show that all staff employed within the last year have undertaken a detailed orientation programme covering all aspects of service provision.</p> <p>Core training requirements, including competencies, have been identified and have been integrated into the planned training schedule for all staff. All caregivers have either completed or are on the national certificate training pathway. Kitchen staff have not completed required training. Staff informed during interview that they receive additional training at the monthly staff meetings, which was also confirmed in meeting minutes. A training schedule for 2015 was viewed and is varied and comprehensive. Individual staff files include their training records and staff attendance at each training session is recorded.</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>	CI	<p>A policy and procedure on staff numbers and skill mix describes the rationale for staffing O'Conor Memorial Home and rostering, as well as the criteria for any changes in staffing levels. The roster can be adjusted by the general manager if residents' needs indicate and there is evidence of this occurring. This process demonstrates continuous</p>



		<p>improvement.</p> <p>All team leaders, registered nurses and diversional therapists have a current first aid certificate, which meets the requirements. The general manager works five days a week and shares on call with the clinical manager who also works five days. At least one registered nurse covers each shift over a 24 hour, seven day a week roster, primarily assigned to the hospital wing, but available throughout the facility.</p> <p>The roster is developed at least three weeks ahead. Six weeks of rosters were viewed and showed all staff absences have been filled by another staff person. Staff are satisfied with staffing levels and no concerns were expressed by residents or family members interviewed.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>A review of records, interview with the clinical manager and documentation confirmed that information is entered into each resident's integrated file in a timely manner. Records reviewed are current and legible and include the designation of the service provider.</p> <p>Current residents' old notes and archived records are secured in a room specific for records. These were observed to be organised and dated for easy retrieval.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Entries to service documents detail all requirements for both parties on admission to the facility. Records reviewed showed a needs assessment and service co-ordination (NASC) assessment occurs prior to all admissions to ensure admission is appropriate. The facility's service agreement requirements have all been met in the files reviewed.</p> <p>Residents and family interviewed verify the facility ensured the admission was timely and carried out with dignity and respect, taking into account the resident's and family's identified needs.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>One file of a transferred resident was reviewed. The clinical nurse manager confirmed all transfers and discharges included the</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>involvement of the resident, family and GP. The file reviewed was completed with evidence of family and GP involvement prior to the transfer occurring. Interview with the family member confirmed this. Policy reflects the process.</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>Policies and procedures for medication management include each health professional's responsibility in relation to medicine prescribing, administration, reconciliation, dispensing, storage and disposal.</p> <p>The resident's prescription medication is completed and updated by the resident's GP and administered by the facility's RNs or care staff who are competent to perform the task. The records reviewed (four dementia, six hospital level and five rest home care records) were legible and each record signed individually by the GP, including verbal orders. Prescription records consistently included the reason for pro re nata (PRN – as required) medications. When an alteration occurs the GP updates the record in the facility as sighted in records reviewed.</p> <p>Staff members with a current medication competency were observed administering medications, across all three areas, demonstrating safe practice on the days of audit. The medications are delivered monthly from the pharmacy in blister packs. The medications were observed to be locked and securely stored when not in use.</p> <p>Controlled drugs were reviewed, and storage was in line with guidelines and legislative requirements.</p> <p>There was evidence of clinical pharmacy involvement and reconciliation occurring from medication charts reviewed. Discontinued medications are returned to the pharmacy weekly, including controlled medications, as sighted in records sighted by the RN and pharmacist.</p> <p>There was one resident in rest home care reviewed as being suitable to self-medicate medications, complying with the facility's policies and procedures.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>A kitchen management policy addressing safe food handling is in place. This addresses areas of procurement, production, preparation,</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>storage, transportation, delivery and disposal. A four week cycle of menus was sighted.</p> <p>Information on identifying additional or modified nutritional requirement guidelines was addressed through a recent external audit of the four week menu plan by a registered dietitian. Changes and recommendations were made and have been implemented as demonstrated by the residents meeting minutes, menu changes and corrective action activities. Proactive work has been undertaken in this area.</p> <p>Residents are surveyed as to dietary preferences and copies of notes and meal adjustments were sighted as part of the routine practice in the kitchen.</p> <p>Residents are regularly weighed and where necessary, high protein drinks and food supplements are introduced in conjunction with relevant health checks being under taken. Re-evaluation occurs on a regular basis as viewed in documentation provided.</p> <p>The kitchen works with an external provider in maintaining kitchen hygiene and infection control prevention. Areas inspected were clean and in good repair. Staff were knowledgeable. Food stores inspected were all current and dated. Prepared food was sealed and dated. Fridges and freezers were temperature monitored per schedule.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>Interview with the general manager and a review of records confirmed the facility follows current policy in admitting residents into the appropriate area of care, either dementia, hospital or rest home care. The general manager maintains a record of prospective residents and a NASC assessment occurs prior to admission for the appropriate placement. The general manager provided samples of the appropriate areas residents are admitted into.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	<p>FA</p>	<p>The clinical nurse manager confirmed during interview that prior to admission the NASC agency completes an interRAI assessment to ensure the placement is appropriate, and the general manager makes</p>

gathered and recorded in a timely manner.		<p>the final decision based on the assessment. The facility's clinical nurse manager or RN team leader, or RN in either dementia, hospital level or rest home care areas, completes an appropriate assessment on admission to the facility. This assessment includes a pressure area risk assessment, falls risk assessment, continence assessment, nutritional assessment and if required a wound assessment.</p> <p>An interRAI assessment is now being completed on new admissions as verified in records reviewed, and an updated care plan is completed based on the completed assessment. Resident, family/whanau input and appropriate allied health and community feedback is incorporated into the assessment. Reviews occur in a timely manner by the clinical nurse manager RN team leader or RNs in each of the three areas of care. If an issue arises within the evaluation period, an appropriate assessment tool is completed prior to the development of a short term care plan. Examples reviewed showed a consistent assessment and care planning process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The facility's clinical nurse manager or team leader RN, or RN, in each of the three levels of care, dementia, hospital and rest home care, develops the initial care plan following an interRAI assessment and within time frames to safely meet the resident's needs. Residents files reviewed verify the long term plan is completed within three weeks of admission. During interview the clinical nurse manager explained that when progress alters the RN will develop a short term care plan, using appropriate assessment tools. Care staff during interview demonstrated knowledge of the care plan content.</p> <p>Each care plan was complete, comprehensive, and included interventions that reflected the resident's outcome goals following the interRAI assessment. Care plans and reviews identify progress toward meeting goals and if required interventions are altered. Residents and family/whanau confirmed their involvement in care planning and the review process. There was evidence of allied health interventions in the care plans reviewed and this was confirmed during the GP interview.</p>

<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Policies are in place for continence management; management of challenging behaviours; pain management; personal cares; skin management; wound care; death of a resident; and falls prevention. Links with other services was demonstrated through policies and assessment processes.</p> <p>The facilities clinical nurse manager or RNs document appropriate interventions on the resident's short term or long term care plan, based on completed prior assessments and the interRAI assessment tool.</p> <p>Progress notes are written by RNs or carer staff and those sighted confirmed residents needs were met and service delivery was provided in a timely manner. This was verified during interviews with residents, family and staff.</p> <p>GP assessments sighted were detailed on the medical clinical forms in the integrated resident's files and the subsequent intervention included on the resident's short term care plan. The GP confirmed interventions were always completed by the facility staff.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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>A social activities profile was developed by either of the two diversional therapists (DT) in the dementia, hospital or rest home care unit following admission to the facility in all files reviewed. An activity plan was developed following the completion of the resident's long term care plan in the dementia, hospital and rest home care units. Progress notes were observed to be completed daily and report on progress relevant to the resident's individual activity programme and social interactions. The general activity programme includes the local shopping run, church services, newspaper reading, arts and crafts, pantomimes, singing groups, outings, entertainers, sing a longs, exercises and word games.</p> <p>Residents and family members interviewed were happy with the content and variety of activities provided.</p> <p>Encouragement has been given from the general manager for both diversional therapists to enrol in the new three year diploma for diversional therapists commencing 2016, with time and financial</p>

		support from the facility.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	Care plan reviews are the responsibility of the clinical nurse manager, RN team leaders and RNs. During interview the clinical nurse manager reported that when progress is less than expected a short term care plan is developed and implemented. Evidence in files confirmed this occurs, including re-evaluation and if required transferring the issue to a long term care plan. Examples were sighted where this has occurred. Files reviewed verified care plans were completed at least six monthly as required.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	A review of integrated files, resident and family/whanau interviews, and one GP interview provided evidence of referral to other health and disability services. During interview with the clinical nurse manger examples were discussed and documentation reviewed of referrals to allied health services.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>A waste management policy is available to staff and describes current practices. The disposal of waste, infectious and hazardous substances is being managed according to identified legislative and local council requirements. Recycling and general waste wheelie bins are put out for weekly collection and a contractor may be called to dispose of additional waste.</p> <p>Personal protective equipment including plastic aprons, disposable gloves, masks and protective eye goggles are available throughout the facility. Staff were observed to be using these and during interview spoke of reasons why it was important to protect themselves.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	The Building Warrant of Fitness was sighted with an expiry date of May 2016. All associated systems and plant were reviewed as part of this process and verified as compliant.

		<p>The physical environment is safe, with non-slip surfaces in bathroom areas, handrails along hallways, with space in all areas for people to mobilise independently. Residents and family members informed they like the environment.</p> <p>External areas at the front of the facility and at the side entrance have been tidied to allow safe access to and from the expansive outdoor areas surrounding the building. The internal courtyard also has easy access onto the artificial lawn.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is an adequate numbers of toilets and shower facilities for all residents with a number of rooms with an ensuite. There are toilet facilities close to communal and dining areas for ease of access for residents. Separate staff and visitor toilet facilities are available.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are a range of rooms, with those in the hospital and dementia wings having full ensuite facilities. The general manager spoke of potential residents and their family members being shown rooms' available specific for the level of care required. The rooms in the rest home wing all vary in size, with the smallest rooms being of an adequate size for the resident and an assistant and aid to move around. Rooms were seen as being personalised by the resident and their family members to the degree they wish. This included bringing in their furnishings and pictures.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are a number of lounges and areas in the wide corridors where groups of residents and their visitors can sit. Activities were observed being carried out in two lounge areas while other residents were sitting in other areas.</p> <p>Three dining areas were seen in use and the clinical manager and a RN spoke of residents sitting where they wished but some residents being seated in an area that maintained their dignity while eating.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Cleaning duties are shared between a person with designated duties and care staff. All laundry services are undertaken on site according to documented processes. Commercial units are used for washing and drying laundry with the outdoor washing line used whenever practicable.</p> <p>Laundry and cleaning monitoring occurs six monthly as part of the internal audit process, the results of which are reviewed by the quality manager. Hazardous substances, such as cleaning and laundry chemicals, have been identified and are being stored securely.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is a fire service approved evacuation plan and fire drills were seen as occurring six monthly. Training on emergency occurs as part of orientation and on an on-going basis.</p> <p>There is a standby generator available for use at the facility.</p> <p>A store of food and water is available, water is also stored in a number of hot water cylinders that could be accessed; this was seen as meeting the needs of residents and staff for at least three days.</p> <p>Call bells and an emergency bell are available by patients' beds, toilets and lounge / dining areas. When activated the area is displayed on screens throughout the facility. The general manager and clinical manager stated that the emergency bell is sometimes rung by mistake by residents and staff respond quickly.</p> <p>Security is by all staff ensuring all doors are locked and windows closed before dark. External lights provide light at night. There have been no recent security issues.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All rooms have external windows and heating is provided by ceiling and some areas also have under floor heating. Each room has its own temperature control. The maintenance person monitors the temperature of the rooms on an on-going basis.</p>



<p><b>Standard 3.1: Infection control management</b></p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>A comprehensive package of policies and procedures and guidelines appropriate to the service are in place. The general manager, clinical nurse manager, quality coordinator, and two infection control RN representatives comprise the infection control committee and work across the three wings (dementia, hospital and rest home care), and take responsibility for infection control. The infection control committee interviewed, reported they attend an infection control training programme each year to refresh and further their infection prevention and control knowledge. From this learning they develop and provide infection control training for all staff. This is evidenced by training records and supported by interviews with staff. The General Manager oversees and is accountable to the O'Connor Memorial Home trust board, who approves changes and amendments as viewed in documentation (June 2015).</p> <p>The infection control programme is reviewed annually and discussed quarterly at the infection control committee meeting, bi monthly at the team leaders meeting and monthly at the staff meeting. Use of antibiotics is documented for surveillance. The results are presented at the infection control committee meeting. A monthly report demonstrates trending and analysis. Areas for improvement are targeted via the corrective action process and addressed via the infection control committee meeting.</p> <p>Residents with colds or other illnesses are encouraged to stay in their rooms. Unwell staff are sent home. There are signs on the entrance door asking visitors to stay away if unwell. Strategies are in place to deal with an infectious outbreak should this occur, such as in 2014 when there was a noro virus outbreak which was contained and controlled per infection control policies in a minimal time. There is signage and personal protective equipment to be used in conjunction with established processes.</p>
<p><b>Standard 3.2: Implementing the infection control programme</b></p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of</p>	<p>FA</p>	<p>The infection control committee staff receive in-depth annual training from an external consulting company in Christchurch. All staff receive annual infection control training including hand hygiene, cleaning, and standard precautions.</p>

<p>the organisation.</p>		<p>The infection control programme is audited annually and any recommendations implemented via O'Connor Memorial Home management approval.</p> <p>All three of the infection control committee members were interviewed and were confident in their knowledge of infection control. Other staff interviewed were confident in their knowledge of application of infection control practices.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>There are appropriate documented policies and procedures in place for the prevention and control of infection which reflect current accepted good practice and relevant legislative requirements. These procedures were evidenced and followed appropriately in the containment of a noro virus outbreak in the facility in 2014.</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>	<p>FA</p>	<p>The facility accesses the annual one day infection control refresher training programme run by an infection control specialty service based in Christchurch. The knowledge gained at this training is introduced to support and refresh annual training provided in-house to all staff at the facility.</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>There is a surveillance programme in place. This is well documented with the date evaluated, analysed and trended. Benchmarking has occurred the past two years in relation to urinary tract infections and the rate has declined due to increasing fluid rounds for all residents. Reporting occurs at the monthly staff meeting which includes RNs, carers, kitchen staff and cleaners, bi-monthly team leaders meeting and via a quarterly infection control committee meeting. Adverse outcomes are addressed via the corrective action process and documented. All processes are well documented.</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>O’Conor Memorial Home has a Restraint Minimisation and Safe Practice policy, which uses the definitions from the required standard. Enablers use is voluntary with the resident consenting to the use of the enabler and understanding the potential risks involved.</p> <p>There is a register of residents who use and consent to the use of an enabler. This is maintained by the Restraint Coordinator and is reviewed by the Restraint Minimisation Committee. This was sighted with the general manger and shows that enablers are being reviewed and discussion on the types of enablers used. These include lap belts and bed rails where applicable. There are currently ten residents with enablers in place. Documentation in three files confirmed these are being used according to policy.</p> <p>The general manager stated that no restraint is in use, however one resident in the past year required restraint use for a short time. The resident is no longer at the facility. No restraints were sighted in use during the audit. The Restraint Minimisation Committee reviews the use of restraints on an annual basis, the last meeting minutes were reviewed and no restraints were noted.</p>
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## 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 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	<p>Verification of health professional's annual practising certificates were sighted. A review of staff files verified that all staff employed within the last year have undertaken a detailed orientation programme covering all aspects of service provision. Competency assessments occur for key service components. A detailed training plan is in place for staff, and all care staff have either completed core competency training, or are on the pathway. Two cooks and two kitchen staff have not completed food and hygiene safety certificates. There is evidence they have been enrolled twice, but the polytechnic has cancelled the courses due to insufficient numbers. There is evidence in staff files that care staff have two yearly appraisals. This is confirmed by the general manager and in policy.</p>	<p>The facility's cooks and kitchen staff have not completed food and hygiene safety certificates (modules 167 and 168). Staff appraisals are completed every two years, not annually as required in the service agreement D17.7 f.</p>	<p>Kitchen staff complete the required modules for safe food management. All staff complete annual performance appraisals.</p> <p>180 days</p>

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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	CI	<p>There are policy and procedure guidelines for safe rostering and criteria for adjusting staffing levels. Due to three levels of care at O’Conor Memorial Home documentation reviewed showed there has been extensive work and improvement on ensuring there are above required staffing levels in the south (dementia) wing in the last 12 months. Employment of a second diversional therapist to ensure activities are provided at all times in the south wing was the beginning of this initiative. On review the general manger also increased the registered nurse and care staff input. This has showed an improved outcome for the resident’s quality of life.</p> <p>A further review of the south wing, including staff and family feedback, identified that an extra hour of care time was required to ensure one to one care was required between 3pm and 4pm. The general</p>	<p>The general manager recognised the increased requirements in the south wing for all levels/roles of staff (RN’s, care staff and diversional therapist), above the skill and staffing levels required, and increased these. A review of the process and family and staff feedback has been measured as part of improving the staffing levels, and further adjusting these, which has shown positive outcomes for the residents in the south wing.</p>

		manager increased the hours with an immediate improved outcome for the residents. This approach to increasing staffing levels, a review of the need for increased staffing, including gaining family and staff feedback in the process, and evaluating the process demonstrates an area of continuous improvement.	
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End of the report.