

The O'Conor Institute Trust Board

Introduction

This report records the results of a Partial Provisional Audit; 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 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:

Legal entity:	The O'Conor Institute Trust Board
Premises audited:	The O'Conor Memorial Home
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 9 March 2017 End date: 10 March 2017
Proposed changes to current services (if any):	15 dementia beds, communal and service rooms in a new building
Total beds occupied across all premises included in the audit on the first day of the audit:	53

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

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. There have been no changes to the ownership or the facility since the previous audit. The facility has added a fifteen-bed dementia wing to the existing building which will provide a total of 68 beds.

This audit against the Health and Disability Services Standards included the sampling of residents’ files, interviews with residents, family members 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.

Staff appraisals and food safety training shortfalls have been addressed. There is one area that requires improvement relating to the new buildings certificates for use.

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.



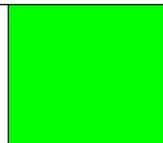
Standards applicable to this service fully attained.

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

There is a complaints process that is understood by residents, family members and staff and meets the requirements of the Code. The general manager maintains a current register.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Standards applicable to this service fully attained.

The O'Connor Memorial Home is a trust with a 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 clinical managers who are registered nurses (RN).

A quality manager oversees the quality improvement plan. Appropriate audits and monitoring is occurring and corrective actions are being undertaken where required. All elements of the quality process are reviewed at the quality meetings. 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. The new building requirements have been included in all relevant policies.

Human resources processes are in place, including ensuring appropriate qualifications on employment. Induction occurs and a training calendar is developed on an annual basis. Staff were being supported to undertake a range of external and internal training opportunities with monthly education sessions and competency reviews. All staff have the appropriate training requirements either completed or in progress.

The general manager oversees the staff rosters and has increased staffing levels in anticipation of the increased number of residents in the new building. This includes clinical managers, registered nurses and additional shifts for care staff.

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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The facility's GM and clinical managers ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the clinical manager/registered nurse (RN) on admission, within the required timeframes. At least one RN is on duty 24 hours a day in the facility. RNs are supported by care staff, clinical managers and general practitioners. Shift handovers 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 were identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme, overseen by an activities coordinator, 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 are consistently implemented using a blister pack system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies and procedures guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and met food safety standards. Residents verified satisfaction with meals. There are sufficient resources to meet the demands of an increased number of residents.

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.		Some standards applicable to this service partially attained and of low risk.
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The new building has been built and furnished to a very high standard. The wide hallway links to the existing environment. Residents' rooms are large and spacious with adjoining full ensuites between two bedrooms. There are three communal areas which provide a variety of spaces for residents to use. There are enough toilets and bathrooms for the number of residents. The new building still requires certificates allocated from the appropriate authorities.

Easily accessed, safe and well maintained outside areas are provided for residents' use. These are designed with the specific resident group in mind.

There are systems in place for the management of waste and hazardous substances by staff who have been trained in this area.

Emergency procedures are documented and available in several places around the facility. Regular fire drills occur and staff are well trained to respond in any emergency. There is a generator available and adequate supplies for civil defence and other emergencies. Appropriate security arrangements are in place. A fire drill incorporating the new building is planned for March.

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 practice policies and procedures are implemented. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, the service had eleven residents with an enabler in the form of either bedrails or wheelchair lap belts. There were no restraints in use.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by the GM as infection control coordinator, aims to prevent and manage infections. Infection control is included in the quality committee and staff meetings. Specialist infection prevention and control advice is accessed from the district health board (DHB) and microbiologist. The programme is reviewed annually.

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	24	0	1	0	0	0
Criteria	0	58	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy which complies with Right 10 of the Code. The general manager and/or the clinical manager commence initial investigation of complaints with input as required from the organisation's quality manager. Complaints forms are visible and available at both entrances. A complaints procedure is provided to residents within the information pack on entry to the service. Complaints are on all meeting agendas. Five complaints in 2016 and two in 2017 were included on the register. All 2016 complaints and one 2017 complaint have been resolved to the satisfaction of the complainant. One is ongoing with documentation and actions within recommended timeframes. The complaints register was up to date.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The facility's Open Disclosure policy describes key principles and explains expectations for the service. Families stated they were kept well informed about any changes to their relative's status. Families were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent reviews. This was supported in residents' records reviewed. There was also evidence of resident/families input into the care planning process. Staff</p>

		<p>understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff were observed taking time to ensure when communicating with residents that they were understood and residents had time to answer.</p> <p>The facility's general manager (GM) 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>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>On the days of the surveillance and partial provisional audit there were 22 hospital care residents, 21 rest home care residents and 10 residents in the dementia wing.</p> <p>The 10 beds in the current dementia wing will be transferred back to hospital beds and are suitable for this purpose, a total of 30. Five beds in the original building can be used as dual purpose for either hospital or rest home. There are 18 rest home only beds. There are 15 beds in the new dementia wing.</p> <p>The strategic and business plan 2016-2017 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. Five key statements identify how the service will meet the principles of the mission statement. There is evidence that the facility actively encourages decision making through resident and family feedback and the wider community.</p> <p>The GM confirmed their commitment to the community of Westport and the residents at O'Conor Memorial Home as the centre of their forward planning and during the recent upgrade and building extensions.</p> <p>The GM has been in her position for over eight years and is suitably qualified and experienced. She is a registered nurse, and has relevant graduate and post-graduate qualifications. The GM is supported in her role by a quality manager and two clinical managers. All three are suitably qualified for their role.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner</p>	FA	<p>In the absence of the GM, the senior clinical manager assumes the role with assistance from the quality manager. The clinical manager will be promoted to a service management role with the appointment of another clinical manager when she returns from leave. In total, there will be three clinical managers. The roles</p>

<p>which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>have been developed to manage the increasing number of residents with the addition of the new building when it opens in April. All have suitable experience for the roles.</p> <p>Staff members interviewed reported that the GM, quality manager, clinical managers and registered nurses are providing stability as the management team of the facility and their respective areas of responsibility. Staff reported that they are approachable with an 'open-door' philosophy. There was evidence of reporting to the Trust Board at all meetings.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>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 safety, and quality improvement meetings, when different aspects of the system were discussed and also included in the manager's reports to the Trust Board. There is then a process to ensure all staff are informed.</p> <p>Current 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 and pressure injuries are agenda items discussed at the monthly staff meetings and quality improvement meetings. A review of the meeting minutes showed evidence of detailed discussions. 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 but the three most recent corrective actions have been closed out.</p> <p>A detailed risk management plan describes how actual and potential risks are to be managed. This was noted to be added to at any time an issue may arise, including for alterations to the outside environment during the building process.</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 incident and accident policy includes the essential notifications and statutory and regulatory reporting, including the requirement to report pressure injuries of category 3 under section 31 of the Health and Disability Services (Safety) Act. The GM demonstrated clearly her responsibility in this area and explained the process, for example, for pressure injury reporting.</p> <p>Adverse events are reported and recorded on appropriate event reporting forms. The data from collated adverse events is summarised by the quality manager monthly and reported at meetings and in graph form on the staff room notice board. Staff confirmed that they report events using the yellow reporting forms, or verbally to the clinical manager, GM or quality manager. They understand the importance of reporting and recording events.</p> <p>General practitioners (GPs) are notified of adverse events when they occur and this was confirmed during interview with one GP who visits the service, and when reviewing event forms. Residents and families reported that they are also notified of events and appreciate receiving this information.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures for recruitment, appointment and management of staff reflect current legislation and good employment practice. All recruitment is managed by the GM with the assistance of the quality manager if required. Both were interviewed during the audit. All appropriate checks are undertaken during the appointment process and this was confirmed during a review of personnel files. Professional qualifications are verified and monitored annually. Records reviewed verify current practising certificates / professional registrations for registered nurses, medical practitioners and allied health professionals. Personnel files reviewed confirmed that all performance appraisals are now current and undertaken for all staff annually. All kitchen staff now have the appropriate training for safe food handling.</p> <p>A comprehensive training and education programme is available for all staff. This includes an orientation and induction programme and ongoing annual training. There is mandatory dementia module training for all staff working in the dementia wing. The facility's managers maintain a training register, which includes essential training, competencies, and other in-service and external training attended by staff. RNs are either trained in interRAI or on the waiting list for</p>

		training. Training includes wound and pressure injury management.
<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>	FA	<p>A staffing policy is in place to alter staffing according to the skill mix and resident's needs. Rosters are the responsibility of the quality manager with oversight by the general manager (GM). Three weeks of non-consecutive rosters reviewed verified adequate care staff on every shift throughout the facility and across all shifts over 24 hours and seven days a week. Clinical managers are supernumerary to staffing numbers. The GM has increased staff in anticipation of increased residents in the new building. This includes a clinical manager, two registered nurses and additional care staff shifts.</p> <p>There are two cooks, seven kitchen hands, three cleaners, a maintenance person and two groundsmen. An additional room service and fluid round shift have been added recently.</p> <p>Three full time activities persons (two of whom are diversional therapists), five days a week provide oversight of activity plans and programmes. The GM, clinical managers and registered nurses share on call. The current staffing levels meet the requirements of residents including for the increased numbers in the new building.</p> <p>Residents, families, staff and the GP interviewed reported that there were sufficient numbers of suitably skilled staff.</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>	FA	<p>Policies and procedures for medication management include each health professional's responsibility in relation to medicine prescribing, administration, reconciliation, dispensing, storage and disposal. There are sufficient resources and space for additional medication storage and management.</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 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</p>

		<p>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, by the RN and pharmacist.</p> <p>There was one resident in the rest home who self-administers medications. Procedures reviewed complied with the facility's policies and procedures and safe practice.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>A kitchen management policy addressing safe food handling is in place. This addresses areas of procurement, production, preparation, storage, transportation, delivery and disposal. A four week cycle of menus was sighted and reflects the current food service.</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 in the residents' meeting minutes and menu changes.</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>There have been changes to staff entry into the kitchen, to allow for the increase in preparation and service that will be required with additional residents. Adequate resources were sighted to meet the food and service demand of more residents.</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 care plan. The facility's clinical manager or RNs document appropriate interventions on the resident's short term or long term care plan, based on clinical information and the interRAI assessment tool.</p> <p>Progress notes are written by care staff and RNs and those sighted confirmed residents needs were met and service delivery was provided in a timely manner. This was verified during interviews with residents, families and staff.</p> <p>GP assessments sighted were detailed on the medical clinical forms in the integrated residents' files and the subsequent intervention included on the residents' short term care plans. The GP interviewed, verified that medical input was sought in a timely manner, medical orders were followed, and care was of a high standard at O'Conor Memorial Home. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Three full time activities people plan and implement the activities programme, one for each service stream. Two are diversional therapists (DT). One activities person was interviewed. The current DT in the dementia wing will transfer to the new wing.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' interests, abilities and social needs. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as their needs change, monthly, and as part of the formal six monthly care plan review.</p> <p>The planned weekly activities programme sighted matches the skills, likes, dislikes and interests identified in assessments. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group</p>

		activities and regular events are offered and the younger residents have activities available to meet their specific needs. Examples included music and singing, planned outings, individual outings, volunteers coming to read to residents, and community groups coming to visit.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the care plan. Examples of short term care plans consistently being reviewed included those for urinary tracts infections (UTIs), falls, infections, skin tears and any changes in the resident's normal status. Progress was evaluated as clinically indicated at least weekly and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressing was changed. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. The health and safety manual includes policy around safe storage and handling of chemicals. Waste is appropriately managed. All chemicals sighted were stored securely. Staff interviewed demonstrated knowledge of handling chemicals and were observed using personal protective equipment. Service rooms in the new building include locks for all cupboards that may store chemicals.</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>	PA Low	<p>The current building warrant of fitness expires 1 June 2017. There has been a 15-bed addition to the facility, which is near completion, since the previous audit. However, the building warrant of fitness, or certificate for public use has not yet been issued.</p> <p>Residents and family members interviewed during this audit reported that they find the current environment is maintained to a high standard at all times and it is</p>

		<p>well presented. A review of the new addition confirms the wing is large, spacious and designed specifically to meet the needs of the residents.</p> <p>There is a regular system for preventative maintenance, relevant electrical safety testing, and calibration of equipment. This was maintained and current. All hazards have been identified in the hazard register, including those identified in the current building environment.</p> <p>Outside areas were easily accessed from the facility and the new gardens sighted were well presented for the residents.</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>Full and spacious ensuites are located between two rooms in 14 of the new bedrooms. One premier room has its own full ensuite. All have hand-washing facilities with soap dispensers and paper towels. There are sufficient showers and toilets for residents. Separate visitor and staff toilets 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>All residents' rooms are very spacious to enable care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents can easily occur and equipment can be transferred between rooms. Mobility aids can be managed in large communal rooms.</p> <p>There was room to store mobility aids such as walking frames and other equipment safely.</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>The new building has one very large communal lounge/dining area. There are two additional lounges for residents and families within the new building. In all communal areas there is generous space for residents to move freely.</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</p>	FA	<p>All laundry except towels and sheets/pillow cases is completed on site in the laundry. A new large commercial washing machine has been purchased in anticipation of the increased laundry requirements with the new building.</p>

<p>the service is being provided.</p>		<p>A survey of residents and family confirmed satisfaction with cleaning and laundry services. The service has secure cupboards for the storage of cleaning chemicals. All chemicals sighted were labelled. Material safety datasheets are displayed and a copy held on the cleaning trolleys. Cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning staff have completed chemical safety training.</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 at least one staff member on duty at all times with a first aid certificate. Emergency plans are accessible to staff and includes management of all potential emergency situations. The organisation has policies and procedures for civil defence and other emergencies. There are enough supplies available, such as dressing and first aid equipment. There is an approved evacuation plan for the facility, although the new evacuation plan for the addition has yet to be signed off by the fire department (refer criterion 1.4.2.1). Fire evacuation training and drills are conducted six monthly.</p> <p>Emergency equipment, water and food are available in a separate area and routinely checked.</p> <p>Appropriate security systems are in place. The call system functions throughout and when activated is responded to promptly. The existing call system is continued in the new building. The service has a visitors' book at reception for all visitors, including contractors, to sign in and out.</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 new building communal areas and residents' bedrooms are provided with large windows to allow natural light, ventilation, and in an environment that is maintained at a safe, comfortable and controlled temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>O'Conor Memorial Home provides an environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IC) programme. Infection control management is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually. The new building has been added to all section in the IC manual, including IC risks during the building</p>

		<p>phase.</p> <p>The GM is the designated IC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly, and tabled at the quality and staff meetings. The quality committee includes the GM, quality manager, clinical managers, and the health and safety officer, and team leaders.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</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>	FA	<p>Surveillance is appropriate for the facility. Data is collated monthly on all infections and includes urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the individual infection register in the resident's integrated notes and infection reporting form. The infection control coordinator reviews all reported infections.</p> <p>Collated data is analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are provided to staff via staff meetings and at handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the trust via meeting reports.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies and procedures for the use of restraints and enablers which comply with the standard. All alternatives to restraints are considered and used before any restraint is used.</p> <p>On the days of audit there were no restraints in use and 11 residents with an enabler. The enablers used were bedrails and wheelchair lap belts. The restraint coordinator is the general manager and was interviewed in relation to this standard. She has attended all training provided at the facility. She demonstrated her understanding of restraint and enabler procedures.</p> <p>Enablers are approved, monitored and reviewed. One resident's file of a person using an enabler was reviewed and all documentation was current and as</p>

		described in the organisation's policies and procedures.
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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)
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	There is a current building warrant of fitness for the existing building, but not the new 15 bed addition. As the building has not yet been completed there is also not a current certificate for public use or signed evacuation plan. The GM confirms the fire department will be undertaking a trial evacuation on 20 March 2017 and will sign the evacuation plan after that.	The new addition to the facility does not have a building warrant of fitness or a certificate for public use and signed evacuation plan.	All building certificates and evacuation plans to be approved by the designated authority Prior to occupancy days

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.