

The O'Conor Institute Trust Board- The O'Conor Memorial Home

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:

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: 7 August 2018 End date: 8 August 2018
Proposed changes to current services (if any):	The service provider is applying for hospital services – medical to be added to their certificate as they are establishing systems that will enable them to provide palliative care services for a District Health Board contract.

Plans are underway for rebuilding the facility's kitchen and laundry. These developments are not expected to have any impact on resident care.

Total beds occupied across all premises included in the audit on the first day of the audit: 59

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 a rest home facility providing rest home, hospital and rest home level dementia care for up to 68 residents. The service is operated by a charitable trust and managed by a general manager, a service manager, a quality manager and two clinical managers.

This certification audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family, management, staff, and a general practitioner. Key messages from all interviewees centred on the excellence of care, the good lines of communication and adequate staffing levels.

This audit has resulted in two continuous improvements in relation to good clinical practice and for the development of a culture of quality improvement within the organisation. Service delivery for a resident in the selected sample and the need for 24-hour behaviour/activity plans in the dementia service were identified as areas requiring improvement.

Consumer rights

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected, as observed by staff behaving in a respectful manner towards residents. Services are provided that support personal privacy, independence, individuality and dignity.

Open communication between staff, residents, and families is promoted, and confirmed to be effective, as seen in reporting on the reportable event form. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

Staff, residents and family members are aware of how to make a complaint. A complaints register is maintained with complaints being resolved promptly and effectively.

Organisational management

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

Standards applicable to this service fully attained.

The scope, direction, goals, values and mission statement of the organisation are described within a strategic business plan. Regular reports on the monitoring and functioning of the service are provided to the Trust Board by the general manager. The general manager of the facility is suitably qualified and experienced.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Quality improvement initiatives are being instituted to address identified shortcomings and to implement new ideas. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented and any essential notifications required have been made. Actual and potential risks, including those for health and safety issues, are identified and mitigated. Policies and procedures support service delivery, were up to date and reviewed regularly.

Human resources processes that include recruitment, appointment and orientation of staff are based on current good practice. A systematic approach is in place to identify and deliver ongoing staff training that supports safe service delivery. Annual individual performance reviews are occurring.

Systems are in place to ensure staffing levels are consistently safe. The staff skill mix is reviewed for each shift, according to numbers and acuity.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family/whānau as well as an invitation to visit the facility.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information from the interRAI assessment, and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities, including activities with other local rest homes, and maintains their links with the community.

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Waste and hazardous substances are well managed. Staff use protective equipment and clothing when applicable. Chemicals, soiled linen and equipment are safely stored.

The facility has been designed to meet the needs of the residents, is well maintained and has suitable equipment available. A current building warrant of fitness is on display, electrical equipment is tested as required and other monitoring systems are in place to ensure the environment is comfortable and safe. External areas are accessible and provide shade and seating.

Linen is supplied from an external contractor, while personal laundry is undertaken on site. Internal audits review the effectiveness of cleaning and laundry processes.

Staff are trained in emergency procedures and participate in regular fire evacuation drills. Suitable emergency equipment and supplies are available for use if needed. Residents reported a timely staff response to call bells. Security is maintained, all residents' rooms and communal areas have windows that provide natural light and the facility was a comfortable temperature on the day of audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation implements policies and procedures that support the minimisation of restraint. Staff expressed and demonstrated a good understanding of expectations around restraint and enabler use and confirmed they receive regular education on the topic. The four approved restraints at the time of audit were only for use when these people go on outings. Nineteen residents have voluntarily agreed to use an enabler. Comprehensive assessment, approval and monitoring processes with regular reviews are occurring.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually by an external agency. Specialist infection prevention and control advice is accessed when needed.

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

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

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	1	47	0	0	2	0	0
Criteria	2	97	0	0	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The O’Conor Memorial Home (O’Conor Home) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in a training session attendance record held on 11 January 2018.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent forms. Establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident’s record. Staff were observed to gain consent for day to day care. There was evidence in the files of residents in the Development West Coast</p>

		(dementia) unit of Enduring Power of Attorney (EPOA) enactment having occurred. Staff received training on 'Advance directives, EPOA and informed consent' on 12 July 2018.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family/whānau members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff are due to undergo training on this topic on 30 August 2018.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaint policy clarifies the differences between concerns, Health and Disability Commissioner (HDC) complaints and other complaints. It includes definitions, timeframes and requirements as described in Right 10 of the Code and describes the process for managing complaints.</p> <p>Information on the complaint process is provided to residents and families on admission and is available in several parts of the facility. Those interviewed knew how to make a complaint and were able to say who they would talk to. Staff interviewed were familiar with the complaint process, knew to advise a manager about any written or verbal complaint and were familiar with the yellow event form on which complaints are recorded.</p> <p>The complaints register reviewed showed that complaints recorded include the nature of the complaint, the name of the complainant, the actions taken and an overview of the agreed resolution. All had timeframes. There were descriptions of follow up and improvements</p>

		having been made where applicable. The general manager is responsible for complaints management and follow up. Four complaints all related to one issue are currently under investigation by the Health and Disability Commissioner (HDC) and the service provider is responding to the HDC requests as they are made. Examples of relevant documentation associated with the response processes were sighted.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission information provided and discussion with staff. The Code is displayed in areas together with information on advocacy services. Additional brochures were available at the nurses' station and main entrance along with how to make a complaint and feedback forms.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room or share a room with another person with their consent. In the new area there is an ensuite shared between two rooms. Doors were observed to be shut during cares.</p> <p>Residents are encouraged to maintain their independence by continuing to be active in community groups and clubs of their own choosing. Care plans reviewed included documentation related to the resident's abilities and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. The diversional therapists (DT) were responsible for obtaining social profiles and formulating activities plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually as was verified from a training session attendance record on abuse and neglect held in</p>

		February 2018.
<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>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The DT was teaching a resident who has a heritage of Māori but has only recently begun to explore her roots. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Residents interviewed reported that staff acknowledge and respect their individual cultural needs.</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>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs during the admission process, and that staff respected these. Residents' personal preferences, required interventions and special needs were included in care plans reviewed. Staff interviewed confirmed that they know where to find cultural needs/desires of residents and work towards meeting them. Staff training was provided on 'culture and support' on 14 June 2018.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family/whānau members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>The managers and registered nurses informed that they attend external training and access research-based newsletters and magazines in order to keep up to date with best practice. Consequently, there is a commitment to encourage staff to implement new ideas, or strengthen older ones, to ensure policies reflect good practice and to utilise specialist community resources such as the diabetes nurse, the wound care nurse and the local specialty nurse for aged care dementia. The general practitioner (GP) confirmed the service providers seek prompt and appropriate medical intervention</p>

		<p>when required and were responsive to medical requests.</p> <p>Throughout the audit there were ongoing references to quality improvement processes that had been implemented. A register of these informed why and how evidence-based practices had been instituted. Some such initiatives were for minor improvements or expected routine updates on practices or documentation. Other initiatives were more significant and were reported to have made observable and positive differences for residents through good practice processes. A selection of four of these were followed through in more depth during the audit and the evidence available contributed to the O’Conor Home receiving a continuous improvement rating for this standard.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. This includes online training and reading updates from external services.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family/whānau members stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed, showing current family contact information on family/whānau record. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, through the local DHB, although reported it had not been 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>	<p>FA</p>	<p>The O’Conor Institute Trust Board, known as O’Conor Home, is a Charitable Trust which provides residential care for all ages for the people who have been assessed as requiring residential care. Currently O’Conor Home can accommodate up to 68 people and holds contracts with the West Coast District Health Board for the provision of residential care: Rest Home (17 of 17 beds occupied); Hospital Care (31 of 35 beds); Dementia Care (secure) (9 of 15 beds); Palliative Care (1); Chronic Health; Close in Age and Condition; Respite Care; Day Care and with the Ministry of Health for Younger Person’s Physical</p>

	<p>Health (1). Numbers in brackets reflect the 59-bed occupancy on the day of audit compared with contracted bed numbers. The facility has an average occupancy of 85 - 90%.</p> <p>The service provider has recently accepted a contract for the delivery of palliative care services. The general manager informed that a registered nurse with previous full-time experience in this field has been employed for two days a week, specifically to assist with these services. Suitable equipment such as subcutaneous syringes has been purchased. Arrangements have been made to link with specialist palliative care district nurses over 24 hours over seven days with the possibility of weekly or daily contact as the care package indicates. These nurses, who operate from the GP surgery, also have access to O’Conor Home’s Medi-Map. Two bedrooms near the office have been prepared for people on this contract. In consultation with all registered nurses, a palliative/end of life care plan has been developed and presented to the quality meeting for approval. Registered nurses have completed externally provided palliative care training and more are scheduled in coming weeks. Options of palliative care training, including internet-based training, are being considered for caregivers. There is one person who has just commenced receiving care under this contract and registered nurses are currently responsible for their care. The actions taken reflect the preparedness of the service to provide palliative care services and are consistent with the requirements for O’Conor Home’s application to have hospital services – medical added to their certificate.</p> <p>All three of the trustees and the members of the management committee are well known members of the community and provide advice and support to the management team at O’Conor Home. They are responsible for the annual development and reviews of a strategic business plan. A sample of monthly reports from the general manager to the management committee and of board meeting minutes showed adequate information to monitor performance is reported. These include topics such as occupancy statistics, financial performance, emerging risks and issues, an overview of quality and risk management data, progress reports, environmental reports, fundraising and quality improvement initiatives.</p> <p>The strategic business plan dated July 2018 includes a growth plan,</p>
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		<p>business background overview, business strategy, description of the team structure and information on business mentors. A strengths, weaknesses, opportunities and threats (SWOT) analysis and critical success factors are described and summarised. The plan includes an analysis on market research, a competitor analysis, a financial plan, a section on compliance, information technology and equipment.</p> <p>The mission statement for the organisation, as noted in the business plan, is about providing high quality care in a homely and safe environment that acknowledges and respects the unique identity of each resident. Core values and objectives centre around providing the best possible care and support to residents, enhancing their lives, encouraging family/whānau and community involvement, employing staff whose focus is on making a positive contribution to the organisation and the lives they care for and to remain fiscally prudent. An approach to care is founded on the quote: 'You do not live in our facility; we work in your home'. Eleven objectives are described within the O'Conor home nursing philosophy.</p> <p>O'Conor Home is managed by a general manager who holds relevant qualifications, which include an Advanced Diploma of Nursing, a Bachelor of Health Science and a Masters of Nursing (Applied). This person has been in management roles for more than 20 years and their responsibilities and accountabilities are defined in a signed position description and an individual employment agreement. During interview, the general manager described involvement in management and related training, access to updated reviews on aged care services, representation for regional aged care services and confirmed knowledge of the sector, regulatory and reporting requirements. The general manager undertakes an annual performance review with the chairperson of the board who reported the board's satisfaction with this person's performance.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The service manager carries out all the required duties under delegated authority when the general manager is absent. Board members are available for additional support. This person has had previous experience in charge of an aged care facility in another country; assists with quality management; restraint and infection control and actively contributes to staff training. The general manager, the service manager and two clinical managers are all registered</p>

		<p>nurses with experience in the sector and will relieve each other and accept responsibility for addressing any clinical issues in the absence of one another. Staff expressed confidence in the current arrangements and said they feel well supported.</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 2017 – 2018 Quality Plan remains current until the end of the year. This plan is in a table format with headings of objectives, action points, person responsible, timeframes and progress. Issues to be addressed are listed under relevant topics of stakeholder/client involvement; Stage 4 Staff and Supply Plan; Quality Assurance; Quality Improvement and Risk Management. The quality and risk management plan reflects the principles of continuous quality improvement and includes the management of incidents and complaints, internal audit activities, corrective action follow-up, an annual resident satisfaction survey, health and safety reviews, monitoring of outcomes, clinical incidents including infections and restraint use. Internal audits are undertaken by the service manager according to a predetermined schedule.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality improvement team meetings, which are held at approximately six weekly intervals. Previous separate meetings for infection control, health and safety and restraint minimisation have now been integrated into these quality and risk team meetings. Various staff meetings are scheduled within different timeframes with registered meetings every four to six weeks, dementia unit staff meetings every eight to ten weeks and monthly team meetings.</p> <p>Staff reported their involvement in quality and risk management activities through having to sign they have read the quality and risk meeting minutes and any new or amended policy and procedure, as well as contributing to compliance with changes as a result of corrective action and quality improvement processes. Relevant corrective actions are developed and implemented to address any identified shortfalls. Resident and family satisfaction surveys are completed annually with the returns for the 2018 version of the survey still coming in. Copies of these were sighted.</p> <p>Policies reviewed cover all necessary aspects of the service and</p>

		<p>contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process (maximum of three years), referencing of relevant sources, approval, distribution, removal of obsolete documents and management of new and changed policy documents.</p> <p>Health and safety policy statements include management and employee responsibilities and staff and managers interviewed were aware of these. The organisation's risk management plan includes risk factors associated with funding, information and communication, human resources, the service environment, facility and property management, care management and organisational management. Risk levels are assigned for each risk as are likelihoods. Monitoring and control measures are detailed with responsibility and completion dates included. The general manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. All of the managers are familiar with the Health and Safety at Work Act (2015) and requirements have been implemented.</p> <p>A hazard register that was sighted which covers various hazards under key areas of general, care provision, food service, laundry/cleaning, clerical and psychological nursing, outside, those specific to O'Conor Home and waste disposal. The register is managed according to identification of the hazard, potential harm; risk rating; hazard minimisation controls and frequency of monitoring.</p> <p>A table detailing continuous improvements at O'Conor Home commenced in 2015. This includes headings of the standard, what was changed and the actions taken, what the review process was, what measurement process was used and an overview of the outcomes or benefits gained. In acknowledgement of the service provider's commitment to quality improvement processes, criterion 1.2.3.6 has been rated as a continuous improvement.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	<p>FA</p>	<p>An open disclosure policy and process includes guidelines for adverse events. A separate incident reporting policy and procedure describes what is to be reported, how it is to be done, who to and when. The use</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>of yellow reportable event forms is clearly described along with follow up processes within the quality and risk management system.</p> <p>Staff document adverse and near miss events on this yellow reportable events form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the management team for discussion at the quality improvement meetings and at relevant staff meetings. The reporting process was evident in meeting minutes reviewed. An adverse event register is broken down into key types of events with examples being bruising, falls and hazards.</p> <p>The general manager described essential notification reporting requirements, including for pressure injuries. Examples of implementation of awareness of this were provided and included the management of an employment dispute, the HDC complaints and a norovirus outbreak to the public health unit in 217. An issues-based audit had occurred in December 2017.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. For example, staff recruitment and selection policies and procedures cover advertising for a job(s), application, selection, police checks, interviewing, referee checks, qualifications checks, eligibility to work in NZ and a completed application. A sample of staff files were reviewed and confirmed the service provider's policies and procedures are being implemented. There is a register of annual practising certificates which shows all were current.</p> <p>An orientation policy document describes the programme, lists the content and states it takes four to six weeks. All staff files reviewed included copies of completed checklists that covered orientation skills, knowledge and competencies. All necessary components relevant to the role were evident. Staff reported that the orientation process prepared them well for their role and confirmed that the two-week buddying process by team leaders may be extended if the new staff person lacks confidence or ability to work independently.</p> <p>Continuing education is planned on an annual basis and includes</p>

		<p>mandatory training requirements to meet contractual requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the District Health Board. At least two managers are internal assessors for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education with the service provider taking advantage of a range of external options to fulfil this requirement. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments with all but one newer registered nurse having these competencies. Records reviewed demonstrated completion of the required staff training. Staff informed during interview that they only need to advise one of the managers of a specific training they would like to attend and, in most cases, this is granted if the topic has the potential to improve their skills or knowledge for their role. Registered nurses have been upskilled in palliative care, especially in relation to medicines and syringe driver proficiency in preparation for an increase number of residents requiring this level of care and support. An on-line training system is being finalised for caregivers to undertake over the next few months.</p> <p>All staff files reviewed had an up to date annual performance appraisal filed in them.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Staff numbers and skill mix policy includes requirements for staffing the facility safely. These include considerations related to acuity, clinical indicators, safety and security, after-hours accessibility, staff speed, fluctuating resident demands, skill level of staff, age and gender mix of staff, family involvement, and availability of equipment are all considered.</p> <p>The policy notes that management are committed to ensuring that adequate numbers of suitably qualified staff are on duty to provide safe quality care over 24 hours a day on seven days a week. There is a roster framework in use, which is reviewed by the general manager. Four weeks of rosters were reviewed. At least one registered nurse is rostered on duty at all times and on night shift she/he is based in the hospital level care area. A clinical manager covers the hospital and dementia service areas, while another clinical manager covers the</p>

		<p>residential areas. Each service area (rest home, dementia care and hospital) also has a team leader and no area is left with a staff person with less than level three of their national certificate.</p> <p>The general manager noted that staffing numbers and skill mix are evaluated on a regular basis whenever core business changes, organisational goals or objectives change, resident selection criteria change and/or business downsizes or grows depending on demand. Safe systems are in place to cover unplanned staff absences and there are after hours on call systems in place to cover both clinical and operational issues. All managers reportedly live only minutes away from the facility.</p> <p>All registered nurses, team leaders, diversional therapists and kitchen staff are required to maintain a current first aid certificate and records sighted show this is occurring. Hence all shifts are covered by a person with first aid expertise. All registered nurses have a medicine competency and as only registered nurses administer medicines, all shifts have a medicine competent staff person on duty. Senior caregivers complete separate competencies for checking medicines such as controlled drugs or applying topical medicines such as creams.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Prospective residents are required to have a needs assessment prior to entering the service and in the event of a person's needs changing. Specific services provided at O'Conor Home are for rest home, hospital level and dementia care. Dementia care residents had evidence of specialist referrals in their files with two having had additional follow-up from the psychogeriatric service since their admissions.</p> <p>O'Conor Home provides a comprehensive information package including information on the Code and advocacy services on request. Prospective residents and/or their families are invited to visit the facility prior to admission to meet with management and view available rooms and have a tour of the facility. The organisation seeks updated information from the NASC and/or GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission.</p> <p>Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. There was evidence of family/EPOA involvement in this process in the files for residents in the dementia service.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHBs 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. Family/whānau reported being kept well informed and included in the process during any transfers of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. Medicines are delivered in blister pack form</p>

<p>guidelines.</p>	<p>from the local pharmacy. Night staff check them against the medication chart and enter them into MediMap. They are stored in folders in a locked cupboard in the drug room along with unpackaged medicines which are labelled for individual residents. The drug room is kept locked and the RN holds the key. Medications on the drug trolley were within the current use by dates.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All medications are administered by RNs who have completed the required medication competency. A register of competent staff and specimen signatures was sighted. The clinical manager confirmed there had been no medication errors since the introduction of the electronic system. Diversional therapists confirmed they had medication competency for when taking residents out for lunch.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>Clinical pharmacist input is provided on request.</p> <p>The records of temperatures for the medicine fridge reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all recording requirements for pro re nata (PRN) medicines met. RNs document the effectiveness of PRN medications given; however as noted in the tracer records in criterion 1.3.3.3, the over sedation of this person had not been adequately reported on, or previously addressed. The required three monthly GP review is consistently recorded on the medicine chart.</p> <p>There was one resident who self-administers medication at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner. Documentation is reviewed three monthly and is in line with policies and procedures.</p>
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		There is an implemented process for comprehensive analysis of any medication errors.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by three cooks and a kitchen team, and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Evidence of recommendations made at that time was observed. The service operates with an approved food safety plan and registration issued by Buller Regional Council. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Food for two other areas of the service is delivered by scan box which has hot and cold storage. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets, allergies and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Those residents requiring modified fluids have their drinks made by care staff at the time required. Special equipment, to meet resident's nutritional needs is available. Residents in the secure unit have access to food and fluids to meet their nutritional needs, at all times. Weights observed during file reviews showed stability with the one exception as noted in the tracer information in criterion 1.3.3.3. Residents and family/whānau interviewed expressed satisfaction with the meals.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.</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>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to NASC is made and a new placement found, in</p>

		consultation with the resident and whānau/family.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and interRAI assessments as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of nine trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment 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>	PA Moderate	<p>Plans reviewed in the hospital and rest home reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>As identified in the corrective action below, there is a need for residents in the Development West Coast unit to have 24 hour activity and behaviour management plans. Care plans throughout the service were otherwise detailed and the issue was more significant for the tracer than for the other people in the dementia care service whose files were reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff at handover. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>In the rest home and hospital, documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available including hoists, mobility aids and</p>

		pressure relieving devices suited to the level of care provided and in accordance with the residents' needs.
<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>The activities programme is provided by three trained diversional therapists (DT), holding the national Certificate in Diversional Therapy and two volunteers. The DTs are each assigned to one of the service areas but work together and combine for some activities. The dementia unit particularly focuses on one to one activity and tasks such as folding washing and working alongside one of the afternoon staff for basic household tasks was reported by staff to assist with the evening restlessness some of these people have. Staff spoke of how they distract residents at various times over the day, including evenings and night times.</p> <p>The activity programme includes bus outings and walks outside when weather appropriate, music, newspaper reading, quizzes, church activities and exercises. Activities reflect normal patterns of life and those who wake during the night, no matter which service they are in, are assisted to resettle. Residents often attend community events held and combine with other rest homes for competitions.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. These contribute towards development of activity plans; however as noted in part of a corrective action in criterion 1.3.5, the activity plans for residents in the West Coast Development unit do not cover a 24 hour period. 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 part of the formal six monthly care plan review. Residents interviewed confirmed they find the programme varied and enjoyable.</p>
<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. Where progress is different from expected, the service responds by initiating changes to the plan of care by setting new goals and interventions. Examples of short term care plans being</p>

		consistently reviewed and progress evaluated as clinically indicated were noted for chest infections and wounds. When necessary, and for unresolved problems these are added to the long term care plans. Residents and families/whānau interviewed confirmed involvement in evaluation of progress and any resulting changes.
<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	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to dietitian and psychogeriatric services. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
<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>Waste, chemical usage and hazardous substance management policies and procedures are in place to guide staff. Appropriate disposal methods for the various types of waste generated were in place. Chemicals and hazardous substances were stored safely.</p> <p>An external company is contracted to supply and manage all chemicals and cleaning products. Material safety data sheets were available where chemicals are stored and staff interviewed knew how to manage the chemicals.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using these items.</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	<p>A current building warrant of fitness with an expiry date of 1 June 2019 is publicly displayed. Documentation reviewed, interviews with maintenance personnel and observation of the environment confirmed that appropriate systems are in place. The systems ensure the residents' physical environment and facilities are fit for their purpose and are safely maintained.</p> <p>Equipment checks are occurring, mobility equipment is able to be used safely and hot water temperatures are being monitored. The testing</p>

		<p>and tagging of electrical equipment and calibration of bio medical equipment and weighing scales is current. Two facility vans used to transport residents are warranted and registered and have first aid kits. The environment was hazard free and residents' independence is promoted. A maintenance request system is in place with 'sign offs' evident when tasks are completed.</p> <p>External areas are safely maintained and are appropriate to the resident groups. Verandas provide shelter and the manager informed a sail shade is erected in one area during summer months. The Development West Coast (dementia care) unit has its own safe external courtyard with walking paths, seating and items of interest that include raised vegetable gardens and an old car they can sit in. Residents have access to a 'Men's shed' under supervision and at times the staff take groups over to the chicken house and run.</p> <p>A transportation of residents' policy and procedure covers ambulatory and non-ambulatory residents, describes safety requirements, and covers a range of circumstances.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. These include one full ensuite and seven shared ensuites in the Development West Coast unit (dementia service). One rest home area has nine rooms, each of which has its own ensuite, while other areas have a mix of ensuites, shared ensuites, toilets off the bedroom and shared toilet and shower facilities. All rooms that do not have an ensuite have a hand basin. Privacy locks are in situ.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is sufficient personal space in residents' bedrooms that enables the residents and staff to move around within the bedrooms safely. Although some bedrooms are large, they predominantly provide single accommodation. The only room sharing currently occurring is for a husband and wife who have chosen to share. Rooms are personalised with furnishings, photos and other personal items displayed.</p>

		There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents confirmed the adequacy of bedrooms.
<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>Large communal areas are available for residents to engage in activities. There are several sets of dining and lounge areas, plus an activities area, all of which are spacious and enable easy access for residents and staff. Residents can access small areas for privacy, if required. Two private telephone booths are also available. Furniture is appropriate to the setting and residents' needs.</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>	FA	<p>Comprehensive cleaning and laundry service policies and procedures, work schedules and a laundry manual are in place for staff reference. A housekeeping manual that covers housekeeping duties, on site chemicals and disinfectants for example, was also sighted.</p> <p>The service provider contracts with a local provider for the laundering of bed linen and towels. Personal laundry is undertaken on site by dedicated laundry staff who receive some assistance from care staff. The laundry staff person demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. Family members stated that the system works well and when concerned they will take any delicate items home to launder.</p> <p>There is a small designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through internal audit processes as scheduled on the internal audit programme. There was 100% compliance in the most recent audits.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on 24 May 2017. A trial evacuation takes place six-monthly, the most recent being on 16 April 2018. The new</p>

		<p>staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, blankets, radios, torches and gas BBQ's and a burner were sighted and meet the requirements of residents if there is full occupancy and of staff. Water storage tanks are on site, as is a generator, which has just been upgraded to a larger size. The log burners/wood fires in communal areas are available for heating. Emergency supplies are checked six monthly and emergency lighting is regularly tested by the fire compliance company.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place and described in an emergency management plan. These cover the needs of residents in the secure dementia care unit. Staff in the dementia service were aware of what they need to do for these residents in an emergency situation. Security doors that are only unlockable from the inside are in the new wing where the Development West Coast (dementia) unit is. Doors and windows are locked at a predetermined time and staff undertake nightly security checks. The local community neighbourhood watch patrols the premises at night. Staff informed they are advised to ring 111 if they have any security concerns.</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 residents' rooms and communal areas are heated and ventilated appropriately. Residents' rooms have natural light and opening external windows. Heating is provided by a mix of wall mounted heaters and heat pumps in residents' rooms and the communal areas. Log burners are also in communal areas, although were not in use on the day of audit.</p> <p>All indoor areas were warm and well ventilated throughout the audit. Residents and family members confirmed the facilities are maintained at a comfortable temperature. A designated smoking area is available as needed.</p>
<p>Standard 3.1: Infection control management</p>	<p>FA</p>	<p>The service implements an infection prevention and control (IPC)</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>programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually by an external infection prevention and control organisation.</p> <p>The service manager is the designated IPC coordinator and has been in the role twelve months. The role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly at the quality/risk meeting and then by the facility manager to the board quarterly. Changes are reported back to RNs and reported to other staff via handover.</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 responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for twelve months. They have attended relevant study days, as verified in training records sighted and receive updates from their external provider. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</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>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2017 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons</p>

		and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator, and on line training is also utilised. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. The last session was 16 July 2017.</p> <p>Education with residents is generally on a one-to-one basis and has included cough etiquette and hand hygiene.</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 to that recommended for long term care facilities and includes infections of the urinary tract (UTI), soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract (RTI). Each infection reporting form is type specific and lists symptoms for that particular infection (e.g., UTI cloudy urine and RTI cough, fever). The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers so early intervention can occur.</p> <p>A summary report for a recent gastrointestinal infection outbreak 2 Feb 2018 was reviewed and demonstrated a thorough process for investigation. The appropriate authority was notified and processes were put in place.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint minimisation policies and procedures are reviewed every two years and have been reviewed over the last few months. These were reviewed during phase one audit and meet the requirements of the restraint minimisation and safe practice standards. The documents stated that O'Conor Home is committed to restraint minimisation, provide guidance on the safe use of both restraints and enablers, note</p>

		<p>the environmental restraint of the Development West Coast for residents' safety and that physical holds for personal restraint are to be an absolute last resort.</p> <p>The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. This person is also a member of the quality review committee.</p> <p>Approved enablers in this service are bed rails and lap belts, while approved restraints are listed as bed rails, bed belts and lap belts.</p> <p>On the day of audit, the restraint coordinator informed that restraints are used for four people when they are put in wheelchairs to go on outings and enablers for nineteen. These were evident in the restraint and enabler register. A similar process is followed for the use of enablers as is used for restraint use.</p> <p>Any restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff who were also clear about the difference between a restraint and an enabler, including the voluntary nature of the use of the latter.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group, which meets two monthly as part of the quality and risk management meetings, is made up of the service manager (also the restraint coordinator), the general manager, the quality manager, the team leader (hospital), two clinical managers and the diversional therapist/cultural advisor (who is accessed as required). This group is responsible for the approval of the use of restraints and the restraint processes.</p> <p>It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability. All restraints have been approved, and all use of restraints is being monitored and analysed.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. This occurs at orientation with refreshers</p>

		undertaken every two years with the most recent being March 2018. Staff spoken to understood that the use of restraint is to be minimised, how to ensure its use is safe and what documentation is required to be completed.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the standard. The registered nurse and the restraint coordinator described how they undertake the initial assessment with input from the resident's family/whānau/EPOA. The general practitioner is involved in the final decision on the safety of the use of the restraint and this was evident on the assessment forms.</p> <p>The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. In all cases the desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of the four residents who were using a restraint and included the conditions that restraint would be used under, which specifically stated they are only used when these people are on outings. There was no evidence of restraint use during the audit.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint coordinator described how relatives have at times requested the use of a restraint for a family member but that alternatives had been discussed with staff and family members. Sensor mats, low beds and increased observations at vulnerable times were examples of alternatives currently in use.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Monitoring records of restraint use that were sighted included the necessary details. The restraint coordinator was clear that dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained and updated at quality and risk management meetings, which occur every six to eight weeks. All members of the restraint approval group/committee are present at these meetings. The register contained all residents currently using a restraint, or an enabler, and sufficient information is available to provide an auditable record.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint use evaluations and at the restraint approval group/quality and risk meetings. None of the families of the four people using restraint were available to interview, however records of their involvement were evident in the review sections of relevant residents' files.</p> <p>As the current restraints in use are only applied for outings, the restraint coordinator informed that although a monitoring form is used for each episode, a full review is not undertaken for each one. The evaluation covers all requirements of the standard, including the impact and outcomes achieved. The restraint coordinator follows up to ensure the policy and procedure was followed and documentation was completed as required. An example of this was sighted and the restraint coordinator discussed the decision to simplify the monitoring reporting form.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Restraint use is reviewed at the restraint approval/quality meetings, when individual use of them is reported and any pattern of use across the organisation. Meeting minutes reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families.</p> <p>A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented when indicated. Data reviewed, minutes and the staff and management interviews confirmed that the use of restraint only occurs when a person's safety is at risk.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>While undertaking tracer methodology within the Development West Coast unit, a secure unit where people with dementia are receiving care and support, it was observed that the person was not receiving all stages of service provision within timeframes that ensured their safety. Following an inpatient reassessment of this person's needs at the Kahurangi psychogeriatric service in Greymouth, he was returned to O'Connor Home. A specialist report of a month later noted a return to personal conflict with another person, demonstrations of 'violent' behaviour and sleep disturbance. Other interventions were recommended by the specialist and subsequently implemented, although the specialist's</p>	<p>There is a person in the Development West Coast unit who has had significant weight loss; however, was not followed up with a dietetic referral until the day of audit. They also presented as over sedated due to the administration of medicines intended to manage potentially aggressive behaviours. The behaviour management and activity plans on file do not clearly describe suitable interventions to address the presenting issues. There are indications that this person requires a further needs re-assessment.</p>	<p>The person in the Development West Coast unit, who was identified during audit as needing further review and reassessment, has the necessary interventions that ensure the services delivered are provided within timeframes that safely meet their needs.</p> <p>30 days</p>

		<p>review of a specific medicine has not.</p> <p>The clinical record showed that the behavioural management plan in place was not consistent with the level of aggression of this resident. There was no one record where a pattern of this person's behaviour was evident as the MediMap records showed that some nights this person receives more pro-re-nata (PRN) medicines than they had the night before the audit, but did not state why the difference; only some episodes of adverse behaviours had been recorded on the behaviour management record and these did not reflect the use of PRN medicines, progress notes did not always note that the PRN medicine had been used, or what the response to any use of it had been. Although the ongoing and significant weight loss had been identified, there had not been a referral to a dietitian. There was an overall lack of transparency throughout the person's record to demonstrate the extent of the issues discussed and observed.</p> <p>On the day of audit, the person presented as being over sedated to the point they were unable to keep their eyes open, let alone feed themselves. Although high calorie milk shakes were being provided and food is now moulised, weight loss had continued. The GP provided additional information during interview about the management of this person, including difficulties in accessing assistance</p>		
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		<p>from Kahurangi. He informed he too had observed the level of sedation and had already reduced the dose of a medicine earlier in the day. A referral was made to a dietitian after the interview and the service provider had decided to pursue a further referral back to Kahurangi. The general manager proposed to address the problem in the fastest timeframe possible and suggested this be undertaken alongside the DHB portfolio manager. The DHB portfolio manager and her manager were contacted and have agreed on a strategy to improve the management of this resident. These strategies, alongside information and actions taken by the GP have enabled the level of risk for this corrective action to be reduced from high to moderate.</p> <p>An additional issue identified in the tracer's record was that although there was an activity plan and a behaviour management plan, albeit light on detail, neither of these specifically reflected best actions over a 24 hour period.</p>		
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the</p>	<p>PA Moderate</p>	<p>In addition to the tracer file, review of four other residents' records in this service showed that activity plans and a behaviour management plans lacked detail. Review of other aspects of their service plan and progress notes would suggest the information was adequate, as per their assessments. Records and</p>	<p>Residents in the Development West Coast unit do not have individualised activity plans, or behaviour management plans, that cover 24 hours, as required in section E43 b iii and iv of the ARRC agreement.</p>	<p>All residents in the Development West Coast unit have individualised activity plans and behaviour management plans that cover 24 hours, as required in section E4.3 b iii and iv of the</p>

ongoing assessment process.		reports informed they were generally quiet and settled. Due to the specific needs of the tracer and the contractual requirement that 24 hour activity and behaviour plans are expected to be developed and implemented in a timely manner, a corrective action has been raised.		ARRC agreement. 90 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>As per the continuous improvement in criterion 1.2.3.6, there is a culture of implementation of continuous quality improvement initiatives that has emerged within this facility. A number of these initiatives have promoted good clinical practices that are enabling residents overall to receive higher standards of care and for documentation to be more efficient. Suggestions and ideas for these have come through research information, external advice and from internal corrective action processes. Most had documented action plans in place to guide their implementation. Five of the more significant examples of these are outlined below:</p> <p>1. Seven days a week diversional therapy input was introduced into the Development West Coast (dementia) unit following reports of increased restlessness of residents in the afternoon and</p>	<p>A log of quality improvement projects describes a range of initiatives that demonstrate good practice at a level of continuous improvement. Five specific examples include the enhancement of the lives of people in the Development West Coast unit; a ‘mums and bubs’ initiative in the dementia service; improvement in the safety, care and support of residents at night; improved mobility, balance and strength of residents who participate in a yoga programme; and a significant reduction in the overall number of resident falls.</p>

		<p>information available about how responsive some of these residents were to one on one activities. Additional staff were accessed, working hours altered and the process implemented. Evaluations show there has since been a decrease in incidents, decreased restlessness of residents in the unit and observable evidence of residents positively responding to the activities, especially from the additional one on one experiences.</p> <p>2. A new initiative was introduced into the dementia unit integrating new babies and their mums with the residents. This initiative changed community perception of O’Conor Home and their residents. A diversional therapist approached a local Plunket nurse and was introduced to a group of young mums and their babies. These ‘mums and bubs’ were invited to visit O’Conor Home as part of an intergenerational activity. The initial trial was highly successful so became a regular fixture on the activities programme. Participation and engagement of the residents was documented in the progress notes. Residents were observed rocking babies, stroking their heads and engaging with smiles and a ‘sparkle in their eyes’. The engagement continued after the session with residents continuing to talk to one another about memories of their babies, smell, touch, and sounds. The atmosphere remained calm and less agitation was noted. The community expressed positivity as confirmed by newspaper articles. The mothers were delighted with the response and the residents gained meaningful engagement and memories. The evaluation and reviews of this initiative has revealed improved engagement, interaction and recognition of skills once used.</p> <p>3. A second project of note was how the concept of ‘intentional rounding’ on night shifts that had been promoted by a quality consultancy was taken up. A form was designed to ensure accountability and the</p>	
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		<p>process implemented. Results have demonstrated that there is now accountability for routine activities such as toileting regimes, pressure injury prevention interventions and pain level checks for example. Resident benefits have included increased fluid input, improved pain management and evidence of better sleep from increased comfort and reduced night time disruptions.</p> <p>4. A third initiative was in response to managers accessing research advocating yoga as a purposeful exercise for older people. The action plan included objectives and the programme was implemented once there were sufficient interested and mobile residents. Evaluation and review processes have reported better body coordination, mobility and general movement for those involved and some signs of improved health. There is a suggestion it may have contributed to the reduction in the number of falls. The yoga practitioner has reported positive results and attitudes evident among the participants.</p> <p>5. This fourth example has resulted in a more than 50% reduction in the number of residents' falls. The action plan included a revision of the falls assessment tool that now requires individualised reviews after each fall. Updates to the care plan are also made at this time and noted on the form. A process was instigated of a GP visit after each fall and if any resident fell more than three times a month a referral was put through to the falls coordinator. Detailed rehabilitation guidelines and/or strategies for prevention were instituted for each person who had a fall. The increased post falls information has contributed to improved analyses and recommendations at the organisational level through the quality and risk management team. Evaluation and review processes note that the reduction in falls has occurred because of the increased focus on falls prevention, staff using the prevention information obtained for individuals to the wider resident</p>	
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		population and the yoga programme having improved the strength and balance of some people.	
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>A register of quality improvement initiatives was provided for review. Examples within this register varied from responses to corrective actions, ideas presented by staff or from feedback/survey processes. Each identifies the closest standard to the initiative, describes the issue identified as needing changing, details of the review and/or measurement process(es) used and a description of the benefits gained or the outcomes identified following the review processes. More than 40 initiatives are listed on the register and most of these are over and above corrective actions identified from the routine internal audits. Topics vary from addressing staff absenteeism, changes in orientation processes, introduction of electronic equipment, increase of diversional therapy input in the dementia service to cover seven days a week and a revamp of restraint minimisation policies, procedures and practices, to mention a few. Documented benefits gained/outcomes for each topic all reflect how the services have improved as a result of the actions taken with examples being improving residents' safety, enhancing the lives of residents, improvement of nursing/caregiving processes and better ways of meeting compliance requirements. The continuous improvement rating acknowledges the organisation's commitment to continuous quality improvement and the consistency with which this has been happening over an extended period of time.</p>	<p>A wide range of quality improvement initiatives have been implemented at O'Conor Home over the past three years. A register of these describes how residents have directly or indirectly benefited from them and how evaluation and review processes have demonstrated how successful they have been or how they continue to improve systems and processes.</p>

End of the report.