

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 - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 13 September 2021 End date: 15 September 2021

Proposed changes to current services (if any): Plans are underway for O'Conor Home to rebuild the kitchen and laundry commencing October 2021, to extend the dementia service by another ten beds and to increase hospital level beds by another 20.

Total beds occupied across all premises included in the audit on the first day of the audit: 67



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

O’Conor Home (previously known as the O’Conor Memorial Home) provides rest home, hospital level care and dementia services (rest home level) for up to 69 residents. It is the only provider of residential aged care services in Westport. The service is operated by a Charitable Trust, The O’Conor Institute Trust Board and is managed by a general manager and a service manager with support from a quality manager and two clinical managers. Reviews of a reconfiguration of beds to increase the number of dual purpose rest home and hospital beds in 2018 and permission for two additional beds in 2020 following the modification of two rooms were undertaken. These were confirmed as meeting requirements. Residents and families spoke positively about the care provided and informed they are actively involved.

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 members, management, staff and a general practitioner.

This audit has resulted in two areas of continuous improvement in relation to good practices and in the activity programme within the dementia service. There were no areas requiring improvement identified.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

All standards applicable to this service fully attained with some standards exceeded.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of The O'Connor Home when they are admitted. Opportunities are provided to discuss the Code, consent, and availability of advocacy services at the time of admission and thereafter as required.

Services at The O'Connor Home are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

Care for any residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

The O'Connor Home has linkages to a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

Residents and family members are informed about the complaints process when at the time of admission. Additional information is readily available. A complaint register is maintained with evidence that all concerns and complaints are investigated and 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.
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An updated business plan includes the history, scope, mission, values, goals, a development plan, results of various analyses, clear objectives and realistic action plans. This is accompanied by a comprehensive quality plan and a separate detailed risk management plan. The general manager provides the governing body with regular reports on the monitoring and levels of effectiveness of the organisational systems. An experienced and suitably qualified person manages the facility.

Implementation of the quality and risk management system includes collection and analysis of quality improvement data, identification of trends and shortfalls and ensures changes are made towards improvements. Staff are involved in quality and risk issues and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated as per the risk management plan. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance appraisals. Staffing levels and skill mix meet the changing needs of residents and associated challenges are being addressed as they arise.

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.

All standards applicable to this service fully attained with some standards exceeded.

Access to the facility is appropriate and efficiently managed with liaison evident between the Needs Assessment Co-ordination Service at the hospital and the clinical team. Relevant information is provided to the potential resident and their family to facilitate admission to the facility.

The residents' needs are assessed on admission and within the required time frames. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. The residents' files reviewed evidenced that the care provided, and the needs of the residents are reviewed and evaluated on a regular and timely basis. Residents are referred to other health providers as required. Shift handovers promote continuity of care between the shifts in each of the three areas.

The planned activity programme is delivered by three full time diversional therapists. The programme provides the residents with a variety of individual and group activities and maintains their links with the community. There is a facility van available for outings.

Medicines are managed according to the policies and procedures which are based on current best practice and consistently implemented. Medications are administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with any special requirements catered for. Policies guide the food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with the meals provided.

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. Chemicals, soiled linen and equipment are safely stored.

The facility and gardens are well maintained. There is a current building warrant of fitness on display. Electrical equipment is tested as required and residents' personal equipment regularly checked for safety. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Communal areas are spacious and safe and residents' rooms are personalised. The facility meets the needs of residents and was clean. Laundry is undertaken both onsite and offsite, is evaluated for effectiveness and any associated complaints are responded to promptly.

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

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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Organisational policies and procedures on restraint and enabler use meet the requirements of the standard and support the minimisation of restraint use. A restraint coordinator monitors implementation of the policy. Nine enablers were in use at the time of

audit. No restraints were in use. Assessment, approval and monitoring process with regular reviews are occurring for the enablers in use. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and trained infection control nurse, aims to prevent and manage infections. The programme is signed off by the governance group and is reviewed annually. Specialist infection prevention and control advice is accessed from a contracted consultant, the GP and by the local district health board as applicable.

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, as are internal audits to review practices. Results are reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	43	0	0	0	0	0
Criteria	2	91	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>O’Conor Home has policies, procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is discussed at the initial interview stage and staff are given a copy to take. It is also included as part of the orientation process for all new staff employed and is part of the ongoing yearly training programme, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principals and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation’s standard consent form including for photographs and outings. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents is defined and documented, as relevant, in the resident’s record. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed gaining consent for day to day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the service are on display and available throughout the facility in both English and te reo Māori. Family members and residents spoken to were aware of the Advocacy Service, how to access this and their rights to have a support person. Staff were also aware of how to access the Advocacy Service if this is required.</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. The facility encourages visits from family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with the staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy references the Code of Rights and notes that people expressing dissatisfaction to staff must be given the choice as to whether they want the matter addressed as a concern or complaint. Definitions and processes for investigating and managing a concern, a consumer complaint and other complaints, including for a Health and Disability Commissioner complaint are documented. The general manager oversees complaint management and determines appropriate actions.</p> <p>A reportable events form is used either as a face sheet for every concern or complaint received or to document the concern or complaint. In addition to a copy of this form being given to all new residents, additional forms are readily available and can be accessed from staff or located from the receptionist.</p> <p>Complaints are logged into a complaint register, which was sighted. Twenty one complaints have been received, investigated and followed up since January 2020. There were no complaints open at the time of audit.</p> <p>The auditors were provided with information about four complaints investigated by the Health and Disability Commissioner between 2017 and 2019. Documentation related to these was to have been reviewed at the surveillance audit. As that audit was cancelled due to COVID-19, the documents were reviewed during this audit. All of the com-plaints had been investigated and closed out by 2019 with no additional follow up required.</p>
<p>Standard 1.1.2: Consumer Rights</p>	FA	<p>When interviewed, the residents and family/whanau of The O' Conor Home reported being made aware</p>

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. The Code is displayed in English and te reo Māori throughout the facility and each resident has a copy of this in the admission pack. Information on how to make a complaint and provide feedback is available.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and their families confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit when attending to personal cares, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families and the GP. All residents have a private room. There are several lounges located throughout the facility providing quiet areas to chat away from the main communal areas.</p> <p>Residents are encouraged to maintain their independence by participating in community activities and quite often the community activity comes to them. Each resident's care plan includes documentation related to the resident's abilities and strategies to maintain and maximise their independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs have been identified, documented and incorporated into their care 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 be occurring during the orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There were two residents at O'Conor Home that identified as Māori. Staff support residents who identify as Māori to integrate their cultural values and beliefs. The principals of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau. There is a current Māori health plan and guidance on tikanga best practice is available. There are staff who identify as Māori in the facility.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's</p>	<p>FA</p>	<p>Residents and their families verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Staff can access an external interpreter service for residents if required. Residents' personal preferences, required interventions and special needs were included in</p>

<p>Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>all care plans that were reviewed. For example, likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction survey confirmed that the resident's individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed, confirmed that residents were free from discrimination, harassment or exploitation and felt safe. The facility general practitioner also expressed satisfaction with the standard of services provided to the residents. The induction process for staff includes education related to professional boundaries and expected behaviour to support good practice. 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>	<p>CI</p>	<p>The service provides and encourages good practice through evidence based policies, input from external specialist services and allied health professionals, for example hospice, wound care specialists, dieticians, podiatrist, and education for staff. The GP confirmed that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported that they receive management support for external education and access their own professional networks. Ongoing yearly training for RNs and care staff is provided 'in house' due to the geographical location.</p> <p>Documentation sighted and conversations during interviews also demonstrated a commitment to implement continuous quality improvement processes to remedy any identified shortfall, or to improve the residents' lives. These good practices are occurring beyond the usual expectations and have enabled the allocation of a continuous improvement rating for this standard.</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 members stated they were kept well informed about any changes to their own or their relative's status, they are advised in timely manner about any incidents or accidents and the outcomes of regular or urgent medical reviews. This was clearly documented in the residents' records that were reviewed. There was also evidence of resident/family input into the care planning process.</p> <p>Staff understood the principals of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access an interpreter should this be required.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The O’Conor Institute Trust Board, known as O’Conor Home, is a Charitable Trust. An updated business plan 2021 – 2022 for O’Conor Home describes its history and purpose. This includes the mission statement and core values and notes the overall approach to care is founded on the motto of ‘You do not live in our facility, we work in your home’, which was both quoted by managers and staff during the audit and displayed throughout the facility. Analyses of ‘Strengths, Weaknesses, Opportunities and Threats’ (SWOT) are detailed alongside critical success factors and the results of market analysis and financial reviews. Subsequent organisational objectives and operational plans are documented within the business plan, as is a comprehensive development plan. According to the general manager, the key performance indicators from these are reported on using a scorecard system and discussed during the management committee meetings. This was confirmed in a sample of reports and meeting minutes sighted.</p> <p>O’Conor Home is led by a general manager with support from a service manager and a quality manager. The organisation is supported by a group of three trustees and a Management Committee. Business and human resource advice are sought from the Canterbury Chamber of Commerce of which it is a member.</p> <p>The general manager is a registered nurse with 39 years’ experience, has a current practising certificate and has managed O’Conor Home since 2008. Additional educational achievements include an Advanced Diploma of Nursing; a Bachelor of Health Science and a Master of Art (Applied) Nursing. This person has had experience in all levels of rest home management, management roles in large health related organisations and hospitals, palliative care, assessment of Accident Compensation Corporation (ACC) clients, unit standard tutoring and assessment, internal and external contract negotiations, human resource management, project management and internal auditing. Attendance at age care related meetings and applicable conferences is maintained, as are links with the District Health Board portfolio manager for aged residential care and the New Zealand Aged Care Association. A copy of the general manager’s latest annual performance appraisal (December 2020) confirmed competence.</p> <p>Currently O’Conor Home is certified as a 68 bed facility, although has written permission to accommodate 69 residents. It holds contracts with the West Coast District Health Board and the Ministry of Health for the provision of Residential Care, Hospital Care, Dementia Care (secure), Palliative Care, Younger Person’s Physical Health, Chronic Health, Close in Age and Condition, Respite Care, Mental Health Respite Care and Day Care. At the time of audit there were 67 of the 69 available beds occupied. Fifteen of these residents were receiving dementia care (rest home), 21 rest home care and 31 hospital level care, of which one was receiving end of life, palliative care and one was under the younger persons’ with a disability contract.</p>

		<p>Documentation from the Ministry of Health dated October 2018 informed a reconfiguration of bed numbers of specific rest home beds from 18 to 14 and an increase of dual purpose rooms from five to nine had occurred. A check of these changes was made and no concerns were identified. In addition, correspondence from the portfolio manager, with evidence of a copy provided to the Ministry of Health, was sighted. This involved the development of two additional rooms, one of which will be decommissioned when further modifications are made to the building. These changes have seen the facility increase its bed availability from 67 to 69 and are meeting requirements.</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>	FA	<p>The service manager with support from the quality manager takes over specific tasks under delegated authority in the absence of the general manager. This person is a registered nurse of 42 years' experience, has been at O'Conor Home for nearly 10 years and was a care manager in a residential care facility in another country for four years.</p> <p>Despite the recent loss of four registered nurses, there are still four registered nurses working under the direction of the service manager and two clinical managers. During absences of key clinical staff, the clinical management is overseen by one of the other experienced registered nurses in this team. All are experienced in the sector and are able to take responsibility for any clinical issues that may arise. Staff interviewed informed they are comfortable with the overall level of support available.</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>	FA	<p>The organisation has a planned quality and risk system (2021 – 2023), which as noted in standard 1.1.8, reflects the principles of continuous quality improvement. Components of the system include management of incidents and complaints, internal and external audit activities, a regular resident and family satisfaction survey, monitoring of outcomes, clinical incidents including hospitalisations, infections and restraint/enabler use, health and safety review reports, policy/procedure documentation updates and quality improvement projects.</p> <p>A designated quality manager has primary responsibility for implementation of the quality and risk management system. Additional expertise related to infection prevention and control, restraint/enabler use, health and safety and clinical input may be requested. An internal audit schedule is in place and is being upheld. Meeting minutes reviewed are comprehensive and confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quarterly quality meetings. Information emerging from the quality meetings is also discussed at registered nurse meetings, staff meetings and when applicable staff shift handovers. The general manager summarises the information for the management committee meetings.</p> <p>Staff reported their involvement in quality and risk management activities through participation in training, signing off policy documents when read, contributing to policy alteration when practices</p>

		<p>change, audit activities and health and safety compliance.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls in any aspect of the functioning of the home or implementation of the quality and risk management system. Resident and family satisfaction surveys are completed annually. The most recent survey (May 2021) showed some issues around laundry, the menu and participation in care planning. These have either been addressed or actions, such as consultation about care plans, has commenced. Examples of these were viewed.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, as well as health and safety and clinical related documentation that include references to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular one to three years' review processes (which includes all staff), referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>A comprehensive risk management plan is being implemented and ongoing monitoring is occurring. The quality manager and the general manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Five staff, including the quality manager, have undertaken all three levels of health and safety training and are familiar with the Health and Safety at Work Act (2015). The health and safety officer described implementation of the requirements and the general manager spoke of how non-compliance is managed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>An incident reporting policy and procedure covers adverse event reporting. Staff document adverse and near miss events on a bright yellow reportable event form. A sample of reportable event forms reviewed showed these were fully completed and open disclosure with any resident involved and their family/whānau had occurred.</p> <p>All resident-related reportable events are investigated and signed off by a clinical manager and staff incidents are signed off by the general manager. Corrective actions and action plans are developed for individuals to prevent recurrences or stem repeated incidents as indicated. Data related to reportable events is collated and analysed. Actions plans are developed via the quality and risk management system for any evidence of significant risks and any identified patterns or trends. The general manager reports a summary of the incident-related data and follow-up to the management committee meetings. As noted in the continuous improvement rating for standard 1.1.8, Good Practice, data analysis of reportable events has contributed to the identification of continuous quality improvement projects.</p> <p>The general manager and service manager both described essential notification reporting requirements, including for pressure injuries and infections. An example of an essential notification</p>

		report to relevant authorities included the recent resignations of four registered nurses, as they posed a risk of insufficient registered nurse cover across shifts. Another example was the reporting and ensuing updates of the impacts the flooding in the town of Westport in July 2021 had on residents, family and staff of O'Conor Home.
<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>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The staff recruitment and selection policy and procedure describe processes for the approval of new positions, advertising and short listing, interviewing, qualification checks, referee checks, police vetting, orientation from day one and specific duties to be fulfilled. A sample of staff records reviewed confirmed the organisation's policies and procedures are being consistently implemented and records are maintained. Records sighted confirmed qualifications and practising certificates (APCs), where required, are being validated.</p> <p>Staff orientation of two to four weeks includes a set of generic requirements plus all necessary components relevant to the specific role of the new employee. Staff records reviewed showed completed orientation documentation is on staff files. New staff are buddied for two weeks or until the mentor and line manager considers they are confident and competent to undertake their role. A manager interviews the new employee one to three months after commencement to plan the way forward and address any training requirements.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements and the 2021 requirements were viewed. Records of staff attendance are being maintained. The provider has access to two on-line training providers. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's policy and their agreement with the District Health Board. Staff working in the dementia care area have either completed or are enrolled in the required education with various related supplementary education opportunities and forums such as 'Walking in Another's Shoes' also being made available. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. The quality manager, all registered nurses, diversional therapists/activities staff and kitchen staff undertake first aid training every two years.</p> <p>Records reviewed demonstrated annual performance appraisals are being undertaken in partnership with the employees.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	FA	<p>A staff numbers and skill mix policy and procedure lists factors to be taken into consideration when determining staff numbers and skill mix to ensure safe service delivery, 24 hours a day, seven days a week (24/7). These include the acuity and changing service need levels of residents, clinical indicators,</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>such as wound infections, safety and security needs of staff and residents and the fluctuating demands of residents and their families/whanau. Skill level, age mix, family life and personal preferences of staff are also considered.</p> <p>There is a colour coded roster framework that forms the basis of each fortnightly roster. The general manager and the roster administrator described how the above mentioned factors are taken into consideration when developing each fortnightly roster, which covers managers, registered nurses, care staff, and non-clinical staff including kitchen and activities staff.</p> <p>An afterhours on-call system is in place, and the manager described how the recent reduction in registered nurse numbers has increased the use of this. Care staff reported there were adequate staff available to complete the work allocated to them, although there had been additional pressures on staffing numbers and filling unplanned absences since the floods and the lockdown for COVID-19. Staff informed the staffing challenges are being well managed by the manager and the roster administrator.</p> <p>A review of eight weeks of the roster confirmed that despite the challenges of the floods and the lockdown all shifts had been filled by people with relevant skills and that fewer extended shifts, or people working additional shifts, are occurring as time progresses. Diversional therapy/activity staff have been assisting with personal cares when required. These are detailed on the roster, which showed that the use of diversional therapists to assist with resident personal cares has not reduced the scheduled hours for residents' activities. Residents and family interviewed spoke of how hard the staff had worked during the challenges but had no concerns with staffing levels.</p> <p>At least one staff member on duty has a current first aid certificate on each shift and registered nurse coverage in the hospital 24 hour/seven days a week (24/7) is consistently scheduled on the roster.</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 are legible with the name and designation of the person stamped beside the entry.</p> <p>Archived records are held securely in a storeroom on site and are readily retrievable. Resident's records are held for the required period of time before being destroyed. No personal or private resident information was on display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p>	<p>FA</p>	<p>Residents are admitted to O'Conor Home following assessment from the local Needs Assessment Service (NASC), as requiring the levels/types of care provided. For those residents admitted for</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>specialist dementia care all the appropriate documentation for the level of service they require and copies of EPOA's are on file with the required letters of activation. Prospective residents and their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. All residents are admitted to the facility in accordance with current by MOH, COVID guidelines.</p> <p>Family members interviewed stated that they were happy with the admission process and the information that had been provided to them. Files reviewed contained the completed demographic information, assessments, and signed admission agreements in accordance with the contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the Te Nikau, Grey Hospital & Health Centre West Coast DHB 'Yellow Envelope' system to facilitate the transfer of residents to and from acute care settings. There is open communication between all services, the residents, and the family. At the time of transition between services, appropriate information, including medication records and the care plan, is provided for ongoing management of the resident. All referrals are documented in the progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The Medication Management Policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN signs in the medications against the prescription, then signs and dates each blister pack. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. 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 with controlled drugs signed in.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room also had evidence of temperature records taken.</p> <p>Eighteen resident medicine records were reviewed. Good prescribing practices were noted, including the prescriber's signature and date recorded on the commencement and discontinuation of medicines</p>

		<p>and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP reviews were consistently recorded on the medicine record. Standing orders were as per the policy. Verbal orders are rare and must be given to the RN, and then repeated to the HCA. The documentation is then signed and scanned into the electronic patient notes. Vaccines are not stored on site. Residents and staff have received the required COVID-19 vaccines with the exception of those who did not want to be vaccinated.</p> <p>There is a documented process for any residents self-administering medications. This is decided in conjunction with the GP, RN and the resident. Self-medication documentation is completed by the GP and a copy is placed in the notes.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site with a cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietician on the 16 January 2020, with all required recommendations implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Ministry of Primary Industries which expires on the 11th March 2022. The verification visit was not completed due to being cancelled in July due to sickness. This was rebooked for 19th July and again postponed due to the flooding and again rebooked for August. This was also then postponed due to COVID restrictions. There is clear documentation supporting the effort the facility has gone to in order to facilitate this verification visit. Until the local council recommences on site visits this has not been booked. At the time of the audit the kitchen was observed to be clean and the cleaning schedule was maintained. Food temperatures, including for high-risk items, are monitored and recorded as part of the plan using an electronic database.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. There are snacks available twenty hours a day for residents and in the dementia facility trays of sandwiches are also made. The kitchen provides a varied menu which supports residents with specific food requirements. Special equipment to meet resident's nutritional needs is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and families/whānau interviews, satisfaction surveys and in residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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 resident does not meet the entry criteria, there are no vacancies, or the referral has been declined from the service due to inappropriate referral from the NASC service, there is a process in place to ensure that the prospective resident and family are supported to find an appropriate level of care. Examples of this occurring were discussed with the clinical manager.</p> <p>If the needs of the resident change and they are no longer suitable for the services offered a referral for reassessment is made to the NASC and a new placement is found in consultation with the resident and the whanau/family.</p>
<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>On admission, residents of O'Conor Home are assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, cognition and behaviour, nutrition and activities, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents (except for respite, ACC and YPD residents) are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>Those long term residents not being assessed using the interRAI assessment tool have clinical assessments to inform care planning. These are reviewed every six months or if the resident's needs change.</p> <p>Interviews, documentation, and observation verified the RNs are familiar with requirements for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing needs.</p> <p>All residents have current interRAI assessments completed by one of the trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans at O'Conor Home are paper based. When reviewed they reflected the support needs of the residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. For those residents requiring specialist dementia care, a twenty four hour behaviour management plan is also developed. Any change in care required was documented and verbally passed on to relevant staff. Residents and</p>

		family/whanau reported participation in the development and ongoing evaluation of care plans.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews with residents and families verified that the care provided to the residents was consistent with their needs, goals and plan of care. The attention to meeting a diverse range of residents' needs was evident in all areas of service provision.</p> <p>The GP interviewed confirmed that medical orders are carried out in a timely manner and staff are very proactive at contacting the GP should a resident's condition change. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources were available and suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	CI	<p>The activities programme is provided by three full time qualified diversional therapists who support the residents Monday to Friday 8.00am till 4.30pm in the rest home and hospital. The diversional therapist in the dementia facility has opted to work Tuesday to Saturday 10 am till 7 pm to enable them to be able to take some of the residents out into the community at the weekend to watch sport.</p> <p>An activities assessment is completed on admission to ascertain the resident's needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. The activities are evaluated daily and documented once a week and as part of a six monthly multidisciplinary care plan review.</p> <p>Residents in the dementia facility have an in depth 24 hour diversional therapy plan and an assessment on admission to enable the staff to better care for them and understand their needs. There are two residents who identify as Māori and they are greeted in their native tongue and support is given for activities culturally appropriate for them. They are currently celebrating Māori language week. It is the aim of the diversional therapists to get the residents engaging in the community as much as possible. There is a facility van available for weekly outings and the Buller community bus takes residents out also.</p> <p>Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, 'Housie', knitting and visiting entertainers. There are individual, group and gender specific activities for female and male residents. Hospital and rest home residents have a separate activity programme from the dementia residents. There are several lounge areas, as well as the individual's bedrooms where they have the opportunity to watch their own television or listen to the radio. The Activities Calendar is on display and each resident is given a copy of the monthly activities available for them to participate in. It emphasises and celebrates cultural beliefs on a regular</p>

		<p>basis.</p> <p>Residents and families can evaluate the programme through day to day discussions with the activities co-ordinator and by completing the six-monthly resident satisfaction survey. Residents interviewed confirmed the programme was interesting and varied.</p> <p>A continuous improvement rating has been allocated for this standard as an extension to the continuous improvement rating for standard 1.1.8, Good Practice. Although the activities programme throughout the entire service is of high quality, this continuous improvement rating is especially pertinent to the dementia service. The results being achieved with particularly challenging residents in the projects relating: (a) to the introduction of pet therapy; and (b) the provision of worthwhile activities of value for the dementia care residents' are commendable. Work in this area is developing in a manner that is consistent with continuous improvement principles and practice.</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 each shift and reported on in the progress notes. If any change is noted it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI/clinical reassessment or as the residents' needs change. Evaluations are documented by the RN. Where progress is different from that expected, the service responds by initiating changes to the plan of care.</p> <p>Short term care plans are consistently reviewed for infections, pain, weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressings were changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<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	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in the residents' files, including to the district nurses for specialist wound care. The resident and the family/whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as ringing an ambulance if the situation dictates.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Policies and procedures on the management of waste and hazardous substances cover collection and disposal of general waste items, foul/soiled waste, sharps, pharmaceutical waste, hazardous waste and recycling, for example. Staff follow these processes using appropriate collection bins and local disposal systems. Household scraps are composted or fed to the hens at the facility as applicable.</p> <p>Housekeeping chemicals are safely stored in lockable cupboards and rooms where material safety data sheets are readily available. An external company is contracted to supply and manage all chemicals and cleaning products. The company provides relevant training for staff at least annually. Staff interviewed knew where the spill kits were and what to do should any chemical spill/event occur. They were also aware of specific precautions to take when in resident areas, especially the dementia unit.</p> <p>A policy on personal protective equipment (PPE) was sighted. Examples of the requirements around the use of PPE, including in relation to the COVID-19 pandemic requirements were described by staff. Various types of gloves, masks, eye protection and protective clothing, such as aprons and gowns, were seen to be in use. Staff confirmed there is ample PPE available for use when required.</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>	<p>FA</p>	<p>A current building warrant of fitness with an expiry date of 6 July 2022 is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with relevant personnel and observation of the environment. Hot water and fridge and freezer temperatures are regularly checked for safety with actions taken if records showed deviation from the expected ranges. The environment was hazard free, equipment is checked and maintained, residents are safe and independence is promoted.</p> <p>External areas are safely maintained by two groundsmen and are appropriate to the resident groups and setting. Courtyards, some of which are enclosed by surrounding buildings are safe and provide various points of interest including gardens, an old vehicle near the dementia wing, bush and a chicken coop. There is a wooden deck with seating off the main lounge area of the dementia service wing and a gradual ramp goes down to the garden. A concrete pathway winds through gardens around the dementia wing. Residents assist with their maintenance and help to plant raised gardens with vegetables. Rural views and mountains are visible.</p> <p>Residents confirmed they would approach one of the staff if any repairs or maintenance is required. Records sighted confirmed any requests are appropriately actioned in a timely manner.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. These include seven showers, seven toilets, 12 rooms have their own ensuite and there are 19 shared ensuites between two residents' rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. There are additional staff and visitor toilet facilities.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>With all residents' rooms between 11 and 14 square metres, there is adequate personal space for residents and staff to move around within them safely. All except two bedrooms provide single accommodation. Residents in the two shared rooms have provided consent and family members have been involved in the decision. The manager informed that one person who was sharing did not like it and is now in a room of their own. Changes are also about to be made to the occupants of one of the shared rooms to enable a couple to be together. All rooms, including in the secure unit, are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff reported the adequacy of bedrooms and residents were happy with their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The facility has a number of communal areas available for residents to engage in activities, including a permanent area for jigsaws and newspapers. Residents can access various areas for privacy, if required. Overall, there are three lounges in the dementia service wing, two in the hospital area and two in the rest home/dual purpose areas.</p> <p>There are three dining rooms, one in each service area. Dining and main lounge areas are spacious and enable easy access for residents and staff and the lounges have their own nooks. 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</p>	FA	<p>Personal laundry is undertaken on site in a dedicated laundry. Bed linen and towels are laundered off site by an out of town contracted provider. The dedicated laundry staff person was interviewed and demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported that laundry is generally managed well and their clothes are returned in a timely manner. Laundry related concerns were evident in residents' meeting minutes,</p>

<p>in which the service is being provided.</p>		<p>which included records of resolution of these as they arose.</p> <p>There are two staff members who constitute the designated cleaning team, one of whom has been in the role for many years. Both have received appropriate training including completion of the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview with one of the cleaning staff and in training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Care staff assist with cleaning tasks during weekends.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme, through spot checks and the complaint system.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>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 described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on 24 May 2017. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in April 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures and the manager described actions taken and community support provided during and after the recent floods in the Westport Township. The general manager and quality manager described procedures for emergency management in the Development West Coast (dementia service) wing, which was consistent with those outlined within the relevant emergency management documentation and health and safety reviews.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas cookers and BBQ's were sighted and meet the requirements for full occupancy and staff on duty. These are checked annually. Emergency lighting is regularly tested. A diesel operated generator is on site and automatically kicks in when the power goes off. The generator is serviced annually by Buller Electricity, which also supplies the diesel. In addition to on-site header tanks, the Buller District Council has installed a 30,000 litre tank connected to the mains supply as well as a 5,000 litre tank. Emergency water is ultra-violet treated. O'Conor Home is included in the local council civil defence plan, which was confirmed in stories related to the recent flooding that did not affect the actual buildings of the facility.</p> <p>Call bells with digital displays alert staff to residents requiring assistance. There are display panels in each corridor plus three screens, one in each office. Call system audits are completed on a regular basis and residents and families reported that staff generally respond promptly to call bells. Any concerns are addressed by one of the managers as soon as they are raised.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time</p>

		and checked as part of evening and night shift duties. There have been no reported security threats.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and one resident's room opens onto a balcony.</p> <p>Heating throughout the facility is provided by hot water radiators with individual adjustment possible in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the room temperatures are comfortable and they do not have any complaints about the temperatures throughout the facility.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. A comprehensive and current infection control manual that has been developed in consultation with a suitably qualified specialist/consultant is available to staff and managers. The infection control programme has been signed off by one of the Trustees and there was evidence that formal reviews of the programme are completed annually.</p> <p>The service manager/registered nurse is the designated infection prevention and control nurse, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the quality manager and the general manager and tabled at the quarterly quality and risk committee meetings. Infection prevention and control matters are also discussed at registered nurse meetings, staff handovers, staff meetings and ultimately at management committee meetings via the general manager.</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 and confirmed this had been further reinforced since the COVID-19 pandemic emerged.</p> <p>A COVID-19 specific policy and procedure has been added to the infection prevention and control manual by the infection control specialist/consultant. Staff confirmed they have received additional and ongoing training on COVID-19 requirements. Appropriate precautions for level two lockdown requirements were in place with a dedicated person at the main entrance ensuring strict sign-in processes were adhered to. All staff and visitors wore masks and uniforms are not worn in public places. Visiting is monitored.</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 infection prevention and control nurse is a registered nurse currently in the position of service manager. Following completion of additional training and ongoing on-line updates this person has appropriate skills, knowledge and qualifications for the role, which they have been in for more than five years. Additional support and information is accessible from an infection control specialist at the DHB, the community laboratory, the GP and public health unit, as required and examples were cited. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The infection prevention and control nurse confirmed the availability of resources to support the programme and any outbreak of an infection. This person also has access to ongoing email updates from the infection prevention and control consultant who provided assistance with O'Connor Home's policy and procedure updates.</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 are available both in electronic and hard copy formats. These reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed by an external infection prevention and control specialist earlier in 2021 and include updated and appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices and described how they are required to read and sign any updated documentation.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation. Ongoing education sessions including via on-line systems are occurring and have been increased in response to the COVID-19 pandemic. These opportunities are coordinated or provided by the infection prevention and control nurse and the specialists responsible for developing the training packages. Opportunities to provide face to face infection related training are taken up when this is possible and examples of this having occurred were viewed. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about</p>

		handwashing, advice about remaining in their room if they are unwell, increasing fluids if they are prone to urinary tract infections and coughing and sneezing into their elbow. Staff noted that understanding and uptake of this information varies depending on the person's cognitive ability to understand.
<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 for infections is described within the relevant policies and procedures and is appropriate to that recommended for long term care facilities. The McGreer definitions and criteria are used to guide the process, which includes infections of the urinary tract, skin and soft tissue, eyes/ears, gastro-intestinal, the upper and lower respiratory tract and wounds. A registered nurse completes the reportable event form, which the infection prevention and control nurse then enters electronically and reviews the information. Related data is collated at the end of each month, compared with falls data to check for any co-relation and reported at both the one to two monthly registered nurse meetings and the quarterly quality meetings. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Any infection related trends, possible causative factors and required action are identified. Graphs are produced that identify trends for the current year, and comparisons against previous years. This is reported to the clinical managers, the quality manager, the general manager and ultimately the management committee. Benchmarking against their own trends according to bed numbers and over previous years has provided assurance that infection rates in the facility are not increasing with evidence of a decrease for some types of infection.</p> <p>Results of internal audits for food, laundry, catheter cares, cleaning, staff health and vaccination rates, plus competency checks for handwashing, checks of 'donning and doffing' of personal protective equipment and spot inspections of wound trollies contribute to the review of infection incidence at O'Connor Home.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. Some minor issues identified during the pre-audit document review were addressed prior the on-site audit. The environmental restraint of the secure dementia service is noted.</p> <p>The service manager who is also a registered nurse is the restraint coordinator. This person provides support and oversight for enabler use and restraint management education in the facility. During interview and in documentation sighted, they demonstrated a sound understanding of the organisation's policies, procedures and practice and role and responsibilities. As well as restraint and enabler use being a component of the orientation programme, staff are scheduled to undertake training on restraint</p>

		<p>and enabler use every two years.</p> <p>On the day of audit, there were no residents using any form of restraint and it was reported by staff and management that there has been no restraint use in this facility for at least two to three years.</p> <p>Assessments, approvals and consents for the use of nine enablers were evident in a register of enabler use. The enablers in use were bedrails with protectors and lap belts on wheelchairs. Five of the residents use both forms of enablers. All were the least restrictive option, are being used voluntarily at the person's request and their use had been reviewed in February and June 2021.</p> <p>Reports on the use of enablers and confirming no restraint use are included in quality and risk meeting minutes and in reports to the management committee.</p>
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

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>In addition to ensure practices are evidence-based and follow current accepted methods of implementation, O’Conor Home has developed a series of quality improvement initiatives that demonstrate there is ongoing improvement occurring in many aspects of service delivery and organisational management. The planning and recording sheet for these was reviewed and showed each initiative commenced at various times throughout 2020 - 2021 (with some earlier) and continue to be reviewed and updated as applicable. A planned approach is taken with the record showing the standard the quality improvement pertains to, what the provider changed, what the review process was and the measurement used/being used, the action plan and a summary of benefits gained/the outcome.</p> <p>Examples of initiatives implemented include:</p> <ul style="list-style-type: none"> - the use of Abbey pain assessments to guide the administration of pain relief when previously two scales were in use - the use and review of antipsychotic medication (a national initiative); the introduction of pet therapy to stimulate non-participating residents in diversional 	<p>Good practice is demonstrated through the implementation of a range of quality improvement initiatives that confirm continuous improvement processes are part of the culture of this service provider and are being used to address corrective actions, ensure staff and resident safety, improve the staff working conditions and enhance the lives of the residents.</p>

		<p>therapy programmes</p> <ul style="list-style-type: none"> - improvements in working relationships between various staff in one of the areas of service delivery and ensuring residents' regimes are more consistent - improvements in the menu and improved consistency of the food according to the dietitian's recommendations - training of a registered nurse to become a phlebotomist to improve resident access to blood tests without them having to travel out of the facility - an upgrade of the working and living environment and improving emergency management; palliative and end of life care - reducing the number of pressure areas at O'Conor Home - ensuring activities in the dementia service are more worthwhile - review of infection control policies and separating clinical policies from these; plus one on falls prevention. <p>Dates of reviews, what has been reviewed and how they have happened are detailed under each project. Marked improvements are evident with falls now below the national average for every month except one for 2021, very positive resident and relative feedback for projects, such as not having to go out for blood tests, and pressure injuries progressively reducing from 33 in 2017 to 3 up to September 2021. Several initiatives have been closed as successful. The activities initiatives are further explained in standard 1.3.7. Other improvement projects are showing progress but need additional time to determine the level of success.</p>	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to</p>	CI	<p>All residents in the dementia care unit have a 24 hour activity plan, as required by the ARRC agreement. Continuous improvement processes from the planning and implementation to evaluation and review of these demonstrated that people are now being occupied according to individualised and 'usual' activities. Plans have become more detailed and enable a more hands-on approach and inclusiveness by the residents themselves. Several examples extracted from the multiple ones provided, are listed below. Excerpts from individual resident's activity plan evaluations complemented the documents sighted and observation of the activities being pursued. These include faster settling times when some of the people become agitated and the elimination of the use of anti-psychotic</p>	<p>Continuous improvement processes demonstrate how creative, targeted quality initiatives being implemented in the dementia service are improving the lives of the residents. Planning and review processes confirmed positive results and these are being consistently built on to further enhance the lives of these</p>

<p>the consumer.</p>		<p>medication for one person.</p> <p>The diversional therapist has included household tasks and activities as per usual routines in a home and many of the plans reflected everyday 'normal' lives for these people. Examples include gardening, painting and even vacuuming, for example.</p> <p>A therapy dog has been introduced to improve interaction of non-participating residents and the review processes informs that, not only has this been a resounding success with the majority of the residents in the dementia service, but several people have had significant unexpected positive responses varying from people finally leaving their rooms and/or talking of past experiences.</p> <p>A mothers' and babies group is a development from a programme in another part of the facility. Residents in the dementia service, especially the women have unexpectedly responded by touching, talking and singing with the children.</p> <p>Increasing individual's levels of independence and returning people to previously natural activities has become a target with many residents now making their own drinks, assisting staff with the breakfast service and making parts of meals in the dementia wing.</p>	<p>people in a meaningful way.</p>
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End of the report.