Central Region's Technical Advisory Services
Special Audit

The O'Conor Home Institute Trust Board Westport
T/a O'Conor Memorial Home

Canterbury/ West Coast District Health Boards

Final Audit Report

18 -20 December 2017

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The names of residents, some staff and other persons involved in the audit have been withheld from this report to protect confidentiality.

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1. Executive Summary

Canterbury and West Coast DHBs commissioned TAS to undertake a special audit of The O'Conor Home Institute Trust Board Westport, trading as (t/a) O'Conor Memorial Home.

The audit team visited the O'Conor Memorial Home on the 18-20 December 2017.

The audit had the following objectives:

1. to undertake an independent review of the provider's contractual performance to give the DHB assurance around its capacity to deliver contracted services
2. to undertake an independent assessment of concerns raised with West Coast DHB (WCDHB)
3. to undertake a broad, independent review of organisational management practices at O'Conor Memorial Home and compliance with contracted services
4. to undertake a broad, independent review of current clinical practice and the quality of care at O'Conor Memorial Home to assess the level of risk to residents
5. to undertake an independent assessment of the effectiveness of staffing adequacy, skill and qualifications
6. to undertake an independent assessment of the quality and safety systems and processes of the services provided, and ensure that they include incident management and complaint processes to meet leading practice methodology and outcomes, and that they meet contractual obligations
7. to review resident care in regard to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights
8. to offer a report outlining:
    i. the extent to which concerns can be verified
    ii. the extent to which WCDHB can have confidence in the provider's overall standards of care for residents
    iii. any corrective actions recommended by the auditors to be actioned by the provider.

The audit team found that with the exception of four corrective actions, which are listed below:

- there was sufficient capacity to accommodate residents who may be transferred from Dunsford Ward.
- regarding the investigation of the concerns;
    - with the exception of one resident where staff failed to initially detect a change in their health status, (i.e. an infection, which was later diagnosed and treated successfully), there was no evidence found to support the concerns raised with the DHB regarding the management of patients who experienced a deterioration in their health status
    - there was no evidence found to support the concerns raised regarding restraint minimisation practices. However two corrective actions are required in relation to the management of restraints and enablers
    - there was no evidence found to support the concerns raised with the DHB regarding pain assessment and management
    - there was no evidence found to support the concerns raised with the DHB regarding incident reporting and management. However a corrective action is raised regarding the labelling of health records
    - there was no evidence found to support the concerns raised with the DHB regarding the management of residents post falls

    - there was no evidence found to support the concerns raised with the DHB regarding staffing and skill mix
    - there was no evidence found to suggest that the facility was not being appropriately managed in relation to the above concerns.
- the review of organisational management practices at O'Conor Memorial Home and compliance with contracted services showed that the service was being appropriately managed, and in the areas audited, was compliant with contracted services
- clinical practice was being appropriately provided
- the facility had more than adequate numbers of skilled, qualified staff providing effective care to residents
- there is an established quality and risk management system in place. A corrective action is required regarding the management of consumer complaints
- residents' rights are respected by staff and disciplinary actions are taken if rights are not respected.

The audit team identified the following corrective actions:

- restraint minimisation management practice regarding the use of enablers and restraints needs to comply with the standards and policy
- restraint minimisation management policy and associated documentation needs to comply with the standards
- the identification of residents on their legal records needs to comply with the standards and policy
- consumer complaints management needs to comply with the standards and policy.

All four corrective actions are considered low risk. They relate to the need to review and revise existing documentation and thereafter to provide refresher training for staff.

2. Background

O'Conor Memorial Home is a 68 bed aged care facility located in Westport, providing 23 rest home beds which include 5 dual purpose beds, 30 hospital beds, and 15 dementia rest home level care beds.

The West Coast DHB (WCDHB) is in the process of considering the closure of a DHB owned aged residential care facility (i.e. Dunsford Ward). It is likely that some patients may relocate to O'Conor Memorial Home. The closure is in current consultation with DHB staff.

In the last six weeks, WCDHB has been made aware of a number of concerns related to care of the residents at O'Conor Memorial Home.

The concerns raised related specifically to:-

1. recognition of and response to resident deterioration
2. restraint minimisation and safe practice
3. pain assessment and management
4. incident reporting and management
5. assessment and management post-fall
6. staffing and skill mix
7. organisational management processes in relation to the above concerns.

Given the potential closing of Dunsford Ward, the WCDHB was in a position of a conflict of interest in reviewing these concerns as it may be perceived as favouring a yet to be determined outcome and having undue influence on the outcomes. As such an independent audit was required.

3. Objectives

The audit had the following objectives:

3.1 to undertake an independent review of the provider's contractual performance to give the DHB assurance around its capacity to deliver contracted services

3.2 to undertake an independent assessment of the concerns raised to the WCDHB

3.3 to undertake a broad, independent review of organisational management practices at O'Conor Memorial Home and compliance with contracted services

3.4 to undertake a broad, independent review of current clinical practice and the quality of care at the O'Conor Memorial Home to assess the level of risk to residents

3.5 to undertake an independent assessment of the effectiveness of staffing adequacy, skill and qualifications

3.6 to undertake an independent assessment of the quality and safety systems and processes of the services provided, and ensure that they include incident management and complaint processes to meet leading practice methodology and outcomes, and that they meet contractual obligations.

3.7 to review resident care in regard to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights

3.8 to offer a report outlining:

i. the extent to which the concerns can be verified
ii. the extent to which WCDHB can have confidence in the provider's overall standards of care for residents
iii. any corrective actions recommended by the auditors to be actioned by the provider.

Audit Scope Inclusions

The contract parameters were those of the national aged residential care agreement and WCDHB day care services. The audit team was able to refer to other audits undertaken of the service provider including the certification and surveillance audits.

Audit Scope Exclusions

The audit excluded areas not stated in the scope.

4. Findings

This section outlines the findings as they relate to each of the audit objectives.

4.1 Capacity to deliver contracted services

The audit team were required to undertake an independent review of the provider's contractual performance to give the DHB assurance around its capacity to deliver contracted services.

Findings

The DHB is proposing to close 15 beds at Dunsford Ward, Buller Hospital by 1 March 2018, which may result in existing consumers who require aged residential care relocating to O'Conor Memorial Home. The closure of Dunsford has been discussed in the public domain since 2003.

In preparation for this eventuality and other factors, O'Conor Memorial Home has undertaken a building programme to modernise and expand the facility. In April 2017 it opened a new 15 bed dementia unit to replace its existing dementia service area and other communal areas.

O'Connor Memorial Home provides aged residential care services to consumers who are assessed as requiring rest home level care, hospital level care and dementia services. In addition to long term residential care, the Trust has a DHB contract to provide short-term respite and day care activities to older people living in the community. It has a contract with the Ministry of Health (MoH) to provide services to people with disabilities.

The facility has a total of 68 beds of which 23 are rest home beds, 5 are dual purpose beds (i.e. can be used by either rest home or hospital level residents), 30 are hospital beds and 15 are dementia beds.

On day 1 of the audit, the trust was providing services to 50 residents. Of those 50 residents, 15 were rest home level residents, 23 were hospital level residents (which included 1 young person with a disability who was funded by the MoH) and 12 residents receiving dementia services (which included 2 residents who were awaiting reassessment by the needs assessment and service coordination agency (NASC) to change from Specialist Services/Psychogeriatric/D6 level care to rest home/D3/dementia services level care, which was known to HealthCERT, MoH). No one was receiving respite services or attending day care activities. There were 18 vacancies.

Occupancy rates throughout 2017 averaged around 83 percent.

Opinion

The audit team believe that with the addition of 15 beds, there is sufficient current capacity to accommodate residents who may be transferred from Dunsford Ward.

4.2 Investigation of concerns

The audit team was required to undertake an independent assessment of the concerns raised with the WCDHB.

The concerns raised related specifically to:-

1. recognition of and response to resident deterioration
2. restraint minimisation and safe practice
3. pain assessment and management
4. incident reporting and management
5. assessment and management post-fall
6. concerns relating to safe staffing and skill mix
7. organisational management processes in relation to the above matters.

The concerns are addressed below:

Concern 1: Recognition of and response to resident deterioration

Investigation

The audit team reviewed:

- the policy on caring for residents with deteriorating health
- the procedure staff use for reporting concerns to medical staff
- the clinical records of five residents who had died at the facility since 1 November 2017
- the clinical records of five residents who had a deterioration in their health status and had been either discharged or transferred externally to the DHB or had been readmitted
- the clinical record of one resident who was transferred internally from the dementia unit to the hospital area due to a change in health status

The audit team interviewed staff, external health professionals and other people regarding this concern.

Findings

There are a suite of policies in place to guide the provision of care including a policy on caring for residents with deteriorating health.

Clinical and support staff review the health status of residents on an ongoing basis over each 24 hour period. Clinical records are maintained of the health status of residents and staff document residents' health on each shift.

Residents are able to contact staff at any time, as are family members or visitors. Each resident has access to a call bell to attract staff attention if they are able to and are feeling unwell. Call bells are available in communal areas.

If a caregiver has concerns about a resident's health they have 24 hour onsite access to a registered nurse to assess and investigate any concerns. Registered nurses have 24 hour access to medical advice.

Residents are reviewed at least three monthly by a general practitioner or more frequently if required. Any resident who has a negative change in their health status would be reviewed by a medical practitioner at the time the change was noted, which could be a general practitioner or a DHB medical staff member.

The registered nurses covering the night shift can contact the Foote Ward in Buller Hospital and speak with on call medical staff to gain medical advice. The audit team were informed that the registered nurses who are practising on their own overnight frequently call the Foote Ward medical staff for advice. This is seen as a positive and appropriate use of the service given the circumstances. There are clear instructions in place on the process for registered nurses to follow when calling external medical staff after hours, which outlines the information that needs to be conveyed.

The audit team did not find any evidence in the review of the clinical records of five residents who had died at the facility since 1 November 2017 that staff had acted inappropriately to the resident's change in health status. Change in health status included slow deterioration in their health status and rapid deterioration. Some deaths were expected and others were unexpected. External health professionals were engaged in the care of the residents where appropriate.

The review of the clinical records of the five residents who had been either discharged or transferred externally to the DHB due to a deterioration in their clinical condition or other reason, and who had been readmitted, showed that in one instance staff had failed to detect a change in health status in one resident (i.e. an infection, which was later diagnosed and treated successfully).

A formal apology in response to a complaint about this matter was made to the complainant. The documentation for the other residents showed that they were appropriately transferred, discharged or readmitted.

The review of the documentation of the resident who was transferred internally from the dementia unit to the hospital area due to a change in health status was appropriate.

Opinion

With the exception of the one resident where staff failed to detect a change in their health status (which was later diagnosed and treated successfully), there was no evidence found to support the other concerns raised with the DHB regarding the management of patients who experienced a deterioration in their health status.

Concern 2: Restraint minimisation and safe practice

Investigation

The audit team reviewed:

- the restraint and enabler policies and associated procedures and forms
- the enabler and restraint register for the previous 12 months
- the consent forms of all residents voluntarily using enablers and checked the resident's ability to give informed consent
- the restraint monitoring forms used when restraint or enablers are applied

The audit team interviewed staff and one resident.

Findings

The audit team were advised by multiple staff that restraint (i.e. the practice of restricting a resident's normal freedom of movement to ensure their safety, typically by use of bed rails to stop the resident falling out of bed) was not used in any areas of the rest home, hospital or dementia unit. Enablers (which are used when a resident voluntarily wants staff to apply a restraint for their safety, e.g. a bedrail) were in use. The difference between a restraint and an enabler is that only a resident can voluntarily agree to the use of an enabler whereas restraint use is pre-approved by a person entitled to give consent on behalf of that resident and registered health professionals).

There are policies and associated procedures and forms in place covering the use of restraints and enablers. The restraint policy did not state that restraint was not used in the facility.

Twelve residents were using enablers on the initial day of the audit team's visit. This included one dementia level care resident (refer to comments below).

Environmental restraint was in use for all residents living in the dementia unit. Documentation was in place to show that these residents had been assessed and approved by a needs assessment and coordination agency as requiring dementia care.

Ten resident files had current dated enabler forms consented by the resident and had current re-assessment and review dates for each enabler device consented for use. These ten residents were cognitively able to provide voluntary consent.

Two residents had their enabler forms signed by their enduring power of attorney (EPA).

- One of these residents was not cognitively able to voluntarily agree to the use of the enabler (which was a lap belt when in a wheelchair that was only to be used when in the presence of a staff member or family member). The consent form was signed by a family member. The practice in relation to the resident was not compliant with the NZS 8134:2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards Standard 1.1.4, which requires that the use of enablers shall be voluntary **(refer to Corrective Action 4.2.2.1**). The application of this restraint occurred on 21 September 2017. The resident was discharged from the facility on the second day of the onsite audit. All residents receiving dementia level services by diagnosis are not cognitively able to voluntarily consent to the use of an enabler. If a restraint other than an environmental restraint for residents receiving dementia level services is required such restraints must be approved according to the restraint policy.
- The other resident could voluntarily agree to the use of their enablers and verbally communicate their consent but was not able to physically sign the form and hence the form was signed by a family member. However an enduring power of attorney (EPA) for the resident appears to have been activated on or following 9 August 2017 by the resident's general practitioner. No evidence was found of the activation of the EPA. Before an EPA comes into effect, the person with the EPA must be mentally incapable ('lack the capacity') to make certain decisions or manage their affairs. The medical notes record the resident was "accepting" of the suggestion that the EPA was activated. The audit team believe that if the EPA has been formally activated due to lack of capacity then the enabler needs to be managed as a restraint. If the EPA has not been activated due to a lack of capacity there should be formal documentation in the clinical record to state why the consent for enabler use has not been signed by the resident. The audit team note that the enabler has been in effect since 2 April 2015 and that since then a family member has signed two other consents in the clinical record for the resident to receive influenza immunisations one of which identifies the signer has having Power of Attorney.

The audit team noted that the enabler consent form in use provides the option for a resident's EPA/advocate to sign on the resident's behalf, which is not correct as only the resident may sign indicating voluntary agreement **(refer to Corrective Action 4.2.2.2).** The form requires amendment to only allow the voluntary consent to be signed by the resident. A signed consent demonstrates voluntary approval of the use of the enabler.

The consent form specifies the care and monitoring requirements.

Opinion

There was no evidence found to support the concerns raised with the DHB regarding restraint minimisation practices. However improvements are required to the management and practice of restraint minimisation.

The organisation was not applying restraint practices in accordance with NZS 8134:2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards Standard 1.1.4, which requires that the use of enablers shall be voluntary.

The consent form in use incorrectly indicates that a resident's EPA/advocate may sign on behalf of a resident when an enabler is used.

The informal and widely known policy of the facility is not to use restraint. There is an opportunity for improvement to document this as the preferred policy in the restraint policy when revising the policy documents while accepting that on occasion the use of restraint may be necessary.

Detailed Findings & Corrective Actions

This section details the improvement opportunities identified during the course of the audit. Corrective Actions have been made and each has been prioritised.

Audit Findings	Source	Corrective Action Plan	Risk	Responsibility	Time Frame
4.2.2.1 Restraint minimisation management practice and the use of enablers and restraints- The clinical documentation and practice for use of an enabler was incorrect for a resident in the dementia unit, as the resident lacked the cognitive ability to voluntarily agree to its use. The use of the restraint was not correctly identified by staff. An enabler may only be used for residents who can voluntarily agree to its use. Restraints are used for residents who cannot agree to the use of an enabler. Failure to correctly apply restraints and enablers is a breach of NZS 8134:2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards Standard and the aged residential care agreement.	NZS 8134:2:2008 & Contract	There is a need to apply restraints and enablers correctly to residents, and given the finding, there is a need to re-educate all clinical staff on the correct use of restraints and enablers.	Low	General Manager	30 March 2018

Detailed Findings & Corrective Actions

This section details the improvement opportunities identified during the course of the audit. Corrective Actions have been made and each has been prioritised.

Audit Findings	Source	Corrective Action Plan	Risk	Responsibility	Time Frame
4.2.2.2 Restraint minimisation management policy and associated documentation The policy and associated procedure and consent form for the use of an enabler contains errors with relation to the voluntary use of an enabler. Enablers may only be used for residents who can voluntarily agree to its use. If there is a change in the resident's health status then the use of an enabler needs to be reviewed. No one other than the resident can sign a consent for the use of an enabler. Failure to correctly apply restraints and enablers is a breach of NZS 8134:2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards Standard and the aged residential care agreement.	NZS 8134:2:2008 & Contract	There is a need to review the policy and associated documentation relating to the use of enablers and restraints to ensure it matches the restraint minimisation management standard.	Low	General Manager	30 March 2018

Concern 3: Pain assessment and management

Investigation

The audit team confirmed with staff those residents who were known to experience pain.

The audit team reviewed:

- the policies on pain management and current practice and policy on medicines management and palliative care
- the clinical records of three residents with pain management plans and their medicine management on the Medi-Map system
- the clinical records of two residents who had deceased since 1 November 2016 and who had been referred to the nurse specialist WDHB for pain management.

The audit team interviewed three patients with pain management plans who were cognitively able to communicate with the audit team and interviewed staff.

Findings

The pain management plans reviewed were consistent with policy and accepted clinical practice. The use of analgesia was appropriately administered in accordance with the pain management plans. A record of analgesic administration was documented in the Medi-Map system, which is an electronic system used in aged residential care facilities for medicines management.

All residents are assessed for pain on admission and reviewed as part of their initial assessment and ongoing interRAI assessment processes. They are reviewed thereafter as clinically appropriate.

Those residents who were assessed as requiring pain management cares had a plan implemented. Pain relief medicines were prescribed and charted in Medi-Map.

The practice for any resident who experiences pain or discomfort and/or requests pain relief is that the registered nurse on duty assesses the resident and uses the Medi-Map pain scoring tool to record the level of pain being experienced. Pain relief is administered as prescribed. A record of administered medicines are recorded in the Medi-Map system.

Residents receiving end of life (i.e. palliative) care have pain management plans documented in their care plans and in Medi-Map. The practice is that all residents who require end of life care are referred externally to a nurse specialist employed by WCDHB. The nurse specialist then visits and assesses the resident. The nurse specialist then consults with the registered nurses on duty, the medical specialist from the DHB and the resident's general practitioner. Following this process the resident's medicine management plan is reviewed and anticipatory medicines are charted by the resident's general practitioner. Staff then administer pain relief according to the resident's pain management plan.

Opinion

There was no evidence found to support the concerns raised with the DHB regarding pain assessment and management.

Concern 4: Incident reporting and management

Investigation

The audit team reviewed:

- the policy on incident reporting
- all reported incidents (reportable events) since August 2017
- the incident register
- the management of reported incidents.

The audit team interviewed staff responsible for the management of the incident process.

Findings

The types of incidents reported were found to be consistent with the types of incidents that tend to occur in many aged residential care facilities (e.g. falls, skin tears, and infections).

Staff managed incidents promptly and in line with policy.

Incidents are reported to the registered nurse on duty and are documented by staff on a reportable event form. The form is provided to the manager for further investigation and response. Corrective actions arising from the event are implemented or planned. A record of the incident is maintained in the incident register. Trend analysis occurs. Incidents are reported to the management (i.e. governance) committee.

The audit team noted the widespread practice of staff using resident initials without documenting a name and National Health Index (NHI) number on the reportable event forms **(refer to Corrective Action 4.2.4.1)**. This practice is not consistent with the NZS 8153: 2002 Health Records Standards criteria 1.1.2, which states that both sides of each page of a health record shall be clearly identifiable to an individual resident and include the National Health Index (NHI) number where known.

Opinion

There was no evidence found to support the concerns raised with the DHB regarding incident reporting and management. However a corrective action is raised regarding the labelling of health records with individual identifiers.

Detailed Findings & Corrective Actions

This section details the improvement opportunities identified during the course of the audit. Corrective Actions have been made and each has been prioritised.

Audit Findings	Source	Corrective Action Plan	Risk	Responsibility	Time Frame
4.2.4.1 Identification of residents on legal records There was widespread practice of staff using resident initials without documenting the resident's National Health Index Identifier (NHI) on the reportable event forms. This practice is not consistent with the NZS 8153: 2002 Health Records Standards criteria 1.1.2, which states that both sides of each page of a health record shall be clearly identifiable to an individual resident and include the National Health Index (NHI) number where known. Failure to record NHIs on clinical records is a breach of NZS 8153: 2002 Health Records Standards and the aged residential care agreement.	NZS 8153: 2002 Health Records Standards criteria 1.1.2 & Contract	Staff must use the patient's name and NHI when documenting clinical records and given the finding, there is a need to re-educate all clinical staff on correct practice.	Low	General Manager	30 March 2018

Concern 5: Assessment and management post-fall

Investigation

The audit team reviewed:

- the falls prevention policy
- all reported patient fall incidents since August 2017
- the falls register
- four clinical records of current residents
- the clinical record of a deceased resident who had had a suspected head injury post fall.

The audit team interviewed staff.

Findings

The organisation has a falls prevention policy that aims to maintain or regain a resident's maximum possible mobility. It includes assessment of the resident's mobility, referral to the resident's GP for referral to physiotherapy services, updating care plans six monthly to include resident mobility changes, staff training, removal of hazards, providing a regular exercise programme, the provision of equipment and providing support.

All newly admitted residents are assessed for their risk of falls and assessed thereafter as part of the ongoing interRAI assessment process. Falls management plans are documented in clinical records as appropriate.

The falls risk assessment is recorded and strategies are included in both the mobility care plan and safety care plan as appropriate (e.g. uses a walking frame and staff supervision for mobility). Specific interventions are documented (e.g. engaging in exercise programmes, ensuring the call bell is within reach, full hoist transfers, and physiotherapy review).

Residents were observed by the audit team to be using mobility aides (e.g. walking frames and wheel chairs) and were assisted with mobility as required. Handrails, sensor mats, raised chairs and toilet seats were being used and there were sufficient mobility aides and hoists available.

For those residents who do fall, reportable event forms (i.e. incident forms) are completed and contributing factors to a fall or change in health status are noted. An initial assessment is undertaken by the registered nurse on duty. Various assessments are made thereafter depending on the nature of the fall. Neurological observations are completed for residents who have unwitnessed falls and those residents who sustain possible head trauma.

A post fall risk assessment is undertaken and strategies implemented accordingly (e.g. a health review including a medicines review, the use of a sensor mat, ensuring correct footwear is being used as well as mobility aides). Care plans are amended accordingly.

The GP is notified and family are notified when the resident has sustained a fall.

Incidents are reported to the management (i.e. governance) committee.

There was evidence of effective intervention in a resident who had been a frequent faller. The changes implemented by staff had successfully resolved the problem for the resident.

Opinion

There was no evidence found to support the concerns raised with the DHB regarding the management of residents post falls.

Concern 6: Safe staffing and skill mix

Investigation

The audit team reviewed:

- the staff numbers and skill mix policy
- the staff orientation programme policy
- the employee training and development policy
- the 2017 training plan and records of attendance and the 2018 draft training plan
- the qualifications of staff including those rostered in the dementia unit
- the rosters covering the period 18 September to 10 December 2017
- the generic group activities programme.

Interviews were held with staff.

Findings

Rosters are developed in accordance with organisation's staff rostering schedule for the rest home, hospital and dementia areas. Rosters cover the area that staff refer to as the old wing (which includes a mix of rest home and hospital level residents), the new wing (which includes hospital level residents) and the development West Coast suite (DWC) (which is the dementia unit).

Typically the facility is clinically staffed as follows:

Morning Shift	**Rest Home/Hospital Mixed ("Old wing")**	**Hospital ("new wing")**	**Dementia Unit ('Development West Coast Suite:")**
General Manager and Service Manager (both RNs)	2 full time equivalent (FTE)– 5 days per week Monday -Friday		
Clinical Managers (RNs)	1.6 FTE covering all areas 7 days per week		
Registered Nurses	2 FTE covering all areas 7 days per week		
Caregivers	3 FTE	3.6 FTE	2.6 FTE
Afternoon Shift			
Clinical Manager	1 FTE covering all areas 7 days per week		
Registered Nurses	2 FTE covering all areas 7 days per week		
Caregivers	2.6 FTE	2.6 FTE	2 FTE
Night Shift			
Registered Nurse	1 FTE covering all areas + 1 RN on-call for back up support		
Caregivers	1 FTE	2 FTE	1 FTE

Three housekeeping staff are employed to make residents beds and tidy their bedrooms from 8.30 am to 3 pm, seven days a week, which is very unusual in aged residential care, as this is generally an expected role of the caregivers. This practice frees up caregivers to provide direct care to residents and supplements the caregiver FTE numbers on the morning shift as shown in the above table.

The service employs two FTE diversional therapists (DT) and one FTE activities coordinator who is in the final stages of studying to be a DT. One person manages the activities programme in each area Monday to Friday with staff assistance on the weekends.

Housekeeping staff provide cleaning services seven days a week. They have various shifts between the hours of 8 am to 9 pm.

Laundry staff are employed to manage all laundry. These staff have various part time shifts between 8 am to 1 pm and 2 pm to 9.30 pm and the service operates six days a week.

Additional staff can be rostered on to meet fluctuating resident acuity if necessary.

The above staffing was in place on day one of the onsite audit. On that day the old wing housed 25 residents (i.e. 15 rest home and 10 hospital level); the new wing housed 13 hospital level residents; and the DWC housed 12 residents.

The above staffing numbers of registered nurses and caregivers exceeds aged residential care contract expectations and is considered by the audit team to be a high level of staffing compared to industry norms.

The organisation's staff numbers and skill mix policy defines key factors in determining staff ratios, skill mix and resident acuity. These factors are aligned to the DHB aged related residential care contract staffing requirements and are reflected in the staff rostering schedule shown above.

Additional staff are accessed through existing staff of a casual pool. The organisation has a casual pool of caregivers, one of whom is completing the dementia limited credit programme (LCP) level four unit standard.

It is expected that all registered nurses are registered by the Nursing Council of New Zealand and hold current practising certificates. All caregivers are expected to have or be undertaking training to level four of the national qualifications framework. Registered nurses maintain professional development and education through external programmes (e.g. interRAI, LCP, and the walking in my shoes programme to enhance person-centred dementia care). All registered nurses complete bi-annual first aid and resuscitation (CPR) training.

All new staff have a planned orientation programme and complete an assessment during their orientation period.

An annual training programme covering mandatory training and education programme for caregivers is provided by registered nurses. Attendance in staff training and learning outcomes are documented in staff personnel files and on the training database. The organisation makes provision for staff to access online self-directed training programmes.

The organisation supports registered nurses and caregivers to attend national conferences and specialised training. Registered nurses participate in external education sessions held through the DHB and New Zealand Aged Care Association. Five registered nurses are trained interRAI assessors. Staff turnover of the nine registered nurses was low.

Caregivers are supported to complete training to level four on the national qualification framework.

Six caregivers directly involved in caring for residents in the dementia unit have passed the dementia LCP standards at level four. A further six caregivers employed since February 2017 are on a pathway to completing their dementia LCP standards within their first year of employment. Management and the caregivers are aware that these six caregivers need to complete these standards no later than 12 months after their employment.

Caregivers working in the rest home and hospital are encouraged and supported to complete core competencies to level four qualification standard. At the time of audit the facility employed 36 caregivers over a range of shifts.

Of these 36 caregivers employed at the time of audit, 16 (i.e. 44%) had level 4 qualifications or equivalent, 8 (i.e. 22%) had level 3 qualifications and 5 (i.e. 14%) had level 2 qualifications, with 7 (i.e. 19%) having no qualifications yet.

The organisation has three staff who are recognised as onsite trained assessors for Careerforce qualification marking.

Opinion

The audit team found no evidence to support the concerns raised with the DHB regarding staffing and skill mix.

Concern 7: Organisational management processes in relation to the above matters.

Investigation

The audit team interviewed and assessed the management processes in relation to the above matters.

Findings

Comments have been included directly where relevant in the above concerns.

There is an established system of organisational management, which has been in place for some years.

The facility general manager is a registered nurse with a current annual practising certificate (i.e. APC) who has been employed in the position since 2008. She has post graduate qualifications including a Masters of Arts (applied) Nursing.

The general manager is supported by a service manager who is a registered nurse with a current APC, two clinical managers who are registered nurses with APCs, other registered nurses with APCs and team leaders who are senior caregivers.

The management team is supported by a management committee, who are appointed by the board of trustees.

Opinion

With the exceptions of the corrective actions noted in this report, the audit team found no evidence to suggest that the facility was not being appropriately managed.

4.3 Organisational management practices and compliance with contracted services

The audit team was required to undertake a broad, independent review of organisational management practices at O'Conor Memorial Home and compliance with contracted services.

Investigation

The audit team interviewed the following:

- the chair of the board of trustees
- the chair of the management committee (which acts as the local governance committee)
- the general manager
- the service manager
- one clinical manager
- registered nurses
- caregivers
- two general practitioners who provide services to residents
- a DHB employed registered nurse who visits the facility regularly
- members of the public who had an interest in the audit and wished to be interviewed by the audit team some of whom had expressed the concerns being investigated by the DHB.

The audit team reviewed the following documentation

- copy of the original incorporation documents and background to Trust
- the business plan
- the general manager's report to the management committee November 2017
- minutes of meetings
- the general manager's latest performance review
- employment records of staff.

The audit team spent a total of 25 hours on site during the hours of 8.30 am to 6 pm, which involved witnessing normal management practices in operation.

Findings

The O'Conor Institute Trust, which was established in 1918, is a registered charity. It is governed by a board of trustees, which includes the Mayor of Westport, the Archbishop of Wellington and the West Coast Member of Parliament.

The onsite governance process is conducted by a management committee. The management committee consists of the chair, an administrator/secretary, a local business representative, the chair of the board of trustees, and the general manager.

The day to day organisational management is delegated to the general manager who reports to the management committee and interacts closely with the chair of the management committee. The chair of the management committee conducts an annual performance review of the general manager.

Management meetings are held monthly or as needed.

The general manager's office is located very centrally within the care facility ensuring that she is aware of resident situations as they arise.

A dedicated quality management team of three staff are employed to support the delivery of quality care to residents. This team includes the quality manager and two assistants. The quality manager is not a registered nurse but has a background in quality and holds audit qualifications.

The facility is audited externally on an ongoing basis by an external audit agency for HealthCERT, Ministry of Health. HealthCERT is responsible for ensuring hospitals, rest homes, residential disability care facilities and fertility providers provide safe and reasonable levels of service for consumers, as required under the Health and Disability Service (Safety) Act 2001.

The auditing process involves an external assessment by a Ministry of Health approved audit agency against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) and assessment against the DHB aged residential care agreement. The certification audit occurred in July 2015 at which the facility was certified to operate for a further three years until 15 October 2018. During the certification period an unannounced surveillance audit is conducted by the external agency on or around the midpoint of the certification period. This unannounced surveillance audit occurred in March 2017. The surveillance audit included a review of the proposed extension of 15 newly built dementia beds, communal and service rooms in the new building. Reports of these audits and other audits dating back to August 2010 are available in the public domain at https://www.health.govt.nz/your-health/certified-providers/aged-care/oconor-memorial-home. The latest certification and surveillance reports show a high level of compliance within the areas audited.

Throughout the onsite audit the audit team were able to discuss and witness organisation management practices.

The audit team believe that the chair of the board of trustees and the chair of the management committee have a close working relationship to the business. During interviews they demonstrated that they are knowledgeable of the way the business operates and confirmed that they had faith in the general manager, other managers and staff providing services. Their connections to the local community ensured that they were very mindful of the concerns of the local population with the WCDHB's proposal to close Dunsford Ward and the likely move of patients to O'Conor Memorial Home.

Opinion

With the exception of the corrective actions identified in this report, the audit team found in its review of organisational management practices at O'Conor Memorial Home and compliance with contracted services, that the service was being appropriately managed and in the areas audited, was compliant with contracted services.

4.4 Clinical practice

The audit team was required to undertake a broad, independent review of current clinical practice and the quality of care at O'Conor Memorial Home to assess the level of risk to residents.

Investigation

The audit team interviewed the following:

- the general manager
- the service manager
- one clinical manager
- registered nurses
- caregivers
- two general practitioners who provide services to residents
- a DHB employed registered nurse who visits the facility regularly
- members of the public who had an interest in the audit and wished to be interviewed by the audit team some of whom had expressed the concerns being investigated by the DHB.

The audit team reviewed the following documentation:

- 21 clinical records as they related to specific concerns
- all reported incidents (reportable events) since August 2017
- a sample of consumer complaints received in 2017
- a number of service delivery policies

The audit team spent a total of 25 hours on site during the hours of 8.30 am to 6 pm, which involved witnessing clinical practice.

Findings

The review of the clinical records, as they related to specific concerns and care provided from entry to exit/discharge, showed that care was being provided according to the expectations of the aged residential care agreement with the DHB and the Health and Disability Standards, with the exception of the noted corrective actions referred to in this report.

Interviews with external health providers confirmed that they have confidence in the clinical practice provided to residents and they confirmed that staff consult them and others for their expertise and act on suggestions to promote the health of residents.

Opinion

With the exception of the missed diagnosis of a change in health status in one resident and the corrective actions identified in this report that relate to restraint minimisation practice and documentation in health records, the audit team found no other evidence in its review of clinical practice that services were not being appropriately provided.

4.5 Human resource management

The audit team was required to undertake an independent assessment of the effectiveness of staffing adequacy, skill and qualifications.

Investigation

The audit team reviewed the following documentation:

- human resource policies
- employment records of staff
- rosters.

The audit team interviewed

- 12 current employees
- 3 external health care providers who interact with the staff on an ongoing basis.

The audit team spent a total of 25 hours on site during the hours of 8.30 am to 6 pm, which involved witnessing clinical practice by staff.

Findings

Concern 1, as outlined above in Section 4.2, included a review of the effectiveness of staffing as it relates to the provision of appropriate care for residents.

Concern 6, as outlined above in Section 4.2, included a detailed review of staffing adequacy, skill and qualifications. It included a review of policy, and practice during the period from 18 September to 10 December 2017 and the practice of increasing staff to meet increased patient acuity.

Employment records reviewed confirmed that human resource practices meet accepted human resource practices and follow policies. There is a system of performance management in place.

Interviews with staff revealed that staff are concerned about the changes to aged residential care taking place in the area.

Interviews with external health providers confirmed that they have confidence in the clinical practice provided to residents. It was confirmed that staff consult them and others for their expertise and act on suggestions to promote the health of residents.

Opinion

The audit team found that the facility had more than adequate numbers of skilled, qualified staff providing effective care to residents.

4.6 Quality and risk management systems

The audit team was required to undertake an independent assessment of the quality and safety systems and processes of the services provided and ensure that they include incident management and complaint processes to meet leading practice methodology and outcomes, and that they meet contractual obligations.

Investigation

The audit team reviewed the following documentation:

- a sample of policies, procedures and forms in use including the code of resident rights and responsibilities policy, the advocacy policy and the concerns/complaints policy
- management committee minutes
- all reported incidents (reportable events) since August 2017
- a sample of consumer complaints received in late 2017
- the concerns/complaints log (register)
- the resident admission pack
- the latest certification and surveillance reports published by HealthCERT, MoH

The audit team interviewed the following:

- the chair of the trust board
- the chair of the management committee
- the general manager
- the service manager
- the quality manager
- registered nurses
- caregivers
- external health professionals
- others who had an interest in the service.

The audit team spent a total of 25 hours on site during the hours of 8.30 am to 6 pm, which involved observing clinical practice.

Findings

The service has an established quality and risk management system in place, which is understood and followed by staff. There are a range of policies, and associated procedures and forms in place to guide staff.

Key components of the system include adverse event reporting, consumer complaints management, systems to promote health and safety including infection prevention and control, and systems to promote restraint minimisation. Corrective actions occur when identified. Quality improvement data are collected, analysed, evaluated and the results communicated to staff and the management committee which includes the chair of the board of trustees.

The management committee are aware of the risks to the business. Risks are documented in the business plan.

A concerns/complaints log is maintained and includes documented consumer complaints that had been received, as well as staff and other complaints. Consumer complaints reviewed demonstrated that these complaints had been documented, investigated and responded to in accordance with policy.

The audit team noted that the concerns/complaints policy does not comply with the requirements of Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, right 10 in that the timelines for response do not match right 10 of the Code. Final response letters did not always advise the complainant of the organisation's appeal procedure and in terms of best practice did not advise the system for determining closure, leaving the organisation unclear as to whether complainants were satisfied with the final response and the matters raised were closed. The audit team noted that the policy did not clearly differentiate or define the difference between the management of concerns compared to complaints **(refer to Corrective Action 4.6.1).**

Opinion

With the exception of the corrective actions identified in this report, the audit team found that there is an established quality and risk management system in place. A corrective action is raised regarding management of consumer complaints.

Detailed Findings & Corrective Actions

This section details the improvement opportunities identified during the course of the audit. Corrective Actions have been made and each has been prioritised.

Audit Findings	Source	Corrective Action Plan	Risk	Responsibility	Time Frame
4.6.1 Consumer complaints management The concerns/complaints policy does not comply with the requirements of Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, right 10 as the timelines for response do not match right 10. Final response letters do not always advise the complainant of the organisation's appeal procedure. In terms of best practice, it did not advise the system for determining closure, leaving the organisation unclear as to whether complainants were satisfied with the final response and the matters raised were closed. The policy does not clearly differentiate or define the difference between the management of concerns raised as compared to complaints. The policy and management of consumer complaints must comply with right 10 of the Code. Failure to comply with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, right 10 of the Code is a breach of legislation, the Health and Disability Sector Standards NZ8134.1:2008 and the aged residential care agreement.	Legislation NZS 8134.1: 2008 Contract Best practice	There is a need to ensure the policy and management of consumer complaints complies with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, right 10.	Low	General Manager	30 March 2018

4.7 Consumer rights

The audit team was required to review resident care in regard to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (i.e. the Code of Rights).

Investigation

The audit team reviewed the following documentation:

- a sample of policies, procedures and forms in use including the concerns/complaints policy
- a sample of consumer complaints received in 2017
- the complaints register
- the resident admission pack
- the latest Certification and Surveillance reports published by HealthCERT.

The audit team interviewed the following:

- the general manager
- the service manager
- the quality manager
- registered nurses
- caregivers
- external health professionals
- others who had an interest in the service.

The audit team spent a total of 25 hours on site during the hours of 8.30 am to 6 pm, which involved witnessing clinical practice.

Findings

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (i.e. the Code) is available throughout the facility and pamphlets are included in the resident information pack that residents and or families receive on admission. The admission pack includes information on independent advocacy services.

Information on consumers rights are provided to all staff during orientation. Ongoing refresher training is given as part of the mandatory annual training programme.

With respect to rights one, two, three, five, six, seven and eight of the Code the audit team witnessed that residents are treated with respect by staff (i.e. right one). Where staff did not treat residents with respect, disciplinary action was taken by management, which was confirmed in interviews with staff. There were policies in place to protect residents from discrimination, coercion, harassment and exploitation (i.e. right two). There was policy in place to ensure residents were provided with services in a manner that respects the dignity and independence of the residents (i.e. right three). Residents had the right to effective communication (i.e. right five) and to be fully informed (i.e. right six) and informed choice and consent was provided to residents (i.e. right seven). Residents had the right to support (i.e. right eight).

With respect to right four (i.e. the right to services of an appropriate standard), apart from the resident where a diagnosis of a deterioration in health status was not initially detected, there was no evidence found to show that services were not provided at an appropriate standard.

Regarding right nine, staff are aware of residents' rights in respect of teaching or research.

Regarding right 10 (i.e. the right to complain) there is policy in place (refer to section 4.6 Quality and Risk Management Systems) and there was evidence that residents and relatives were aware of their right to complain and their right to complain to the Health and Disability Commissioner.

Opinion

With the exception of the corrective actions identified in this report, the audit team found that residents' rights were respected by staff and disciplinary actions were taken by management if residents' rights were not respected.

Appendix 1: Risk Rating Definitions

High Risk

The impact and likelihood of the event occurring may result in:

- significant instances of contractual non-compliance and/or inability to deliver against the contract
- intervention required by senior management and the Board to resolve service delivery and quality issues
- serious risk to consumer/patient safety
- financial loss impact of more than 10% of funding.

Medium Risk

The impact and likelihood of the event occurring may result in:

- some instances of contractual non-compliance
- service delivery and quality impacts which require input from the provider practice management team
- moderate risk to consumers/patients safety
- financial loss impact of 5% - 10% of funding.

Low Risk

The impact and likelihood of the event occurring may result in:

- isolated instances of contractual non-compliance
- management of service delivery and service quality issues by team leaders
- minor risk to consumers/patients safety
- financial loss of less than 5%.