

Oceania Care Company Limited - Raeburn Rest Home

Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services 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: Oceania Care Company Limited

Premises audited: Raeburn Rest 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: 3 October 2017 End date: 4 October 2017

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 39

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Raeburn Rest Home provides rest home, hospital and dementia level of care for up to 54 residents. On the day of audit there were 39 residents residing at the facility.

This surveillance audit was conducted against the relevant streamlined Health and Disability Services Standards and the provider's contract with the district health board. The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with residents, family, management, general practitioner, clinical and non-clinical staff.

There were three areas identified as requiring improvement at the last certification audit. The improvements relating to key quality indicators having to be linked to the quality system, enrolment for dementia training and planned activities have been implemented.

There are six areas identified as requiring improvement at this surveillance audit relating to quality improvement data collection, staffing, service provision timeframes; risk assessments; medicines management and food services.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible at the facility.

This information is also brought to the attention of residents and their families on admission to the facility. Residents confirmed their rights are being met, staff are respectful of their needs and communication is appropriate. The service has a documented complaints management system and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Oceania Healthcare Limited is the governing body and is responsible for the services provided at Raeburn Rest Home. The organisation has documented its scope, direction, goals, values and mission statement, and these are communicated to all concerned.

The quality and risk management system and processes support safe service delivery. Systems are in place for monitoring the services provided. The quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status reports.

The service is overseen by the business and care manager who is supported in their role by a clinical manager. The clinical manager is responsible for the oversight of the clinical services in the facility.

There are human resource policies implemented around recruitment, selection, and staff training and development. An in-service education programme is provided for staff.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses are responsible for the development of care plans with input from the residents, staff and family member representatives. The long-term care plans are evaluated within the required timeframes.

The planned activities are appropriate to the residents' assessed activity and recreational needs and abilities. Residents and family expressed satisfaction with the activities programme in place. The residents in the dementia unit have 24-hour activities plans in place.

There is a computerised medication management system in place. All medications are reviewed by the general practitioner according to policy and medication care guides. The resident who is self-administering medication does so according to policy.

Nutritional needs are provided in line with nutritional guidelines and the seasonal menu is reviewed by a registered dietitian.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness. There have been no building modifications since the last audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The Oceania Healthcare Limited company-wide restraint minimisation policy and procedures include methods for minimising restraint and approved alternatives. The definitions of restraints and enablers are consistent with the standards.

There was one resident requesting to use an enabler and three residents using restraints on audit days. The clinical files evidenced the processes of assessments, consent, care planning, monitoring and review for both enablers and restraints are conducted according to the standards and the Oceania Healthcare Limited policy.

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.

The infection prevention and control management systems are in place to minimise the risk of infection to residents, visitors and staff.

The infection control surveillance and associated activities are appropriate for the size and complexity of the service. The surveillance for infection is carried out as specified in the infection prevention and control programme. The surveillance data is collated monthly, analysed and reported at facility's meetings and to the Oceania Healthcare Limited support office.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	10	0	2	4	0	0
Criteria	0	33	0	2	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints management policy meets Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). Complaint forms and the complaint process are accessible to staff, residents and family. Residents and family are advised of the complaints process on admission. Residents and family interviewed demonstrated an understanding of how to make a complaint. Staff confirmed that they understand and implement the complaints process when required.</p> <p>The business and care manager (BCM) is responsible for the management of complaints at the facility. The complaint register for 2017 records 6 complaints, of which one went to the district health board (DHB) and remains open, and another went to HealthCERT and then to the DHB which has been closed out. Complaints are managed with supporting documentation to evidence all investigations and actions taken.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Review of residents' clinical files evidenced timely and open communication with residents and family members. Communication with family members is recorded in the progress notes and on the family communication sheets. Staff and management interviews confirmed family members are kept informed about any change in a resident's condition and if any adverse event occurs. This was evidenced in clinical files reviewed. The family interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident.</p>

<p>conducive to effective communication.</p>		<p>Policies and procedures are in place for accessing interpreter services. Staff and management interviews confirmed there were no residents requiring interpreter services on audit days. Interpreter services are accessible, when required. The resident information pack includes all relevant information, including information for people with dementia.</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>Services are planned to meet the needs of the residents at rest home, hospital and dementia level of care. The service has a documented mission statement, values and goals. These are communicated to residents, staff and family through posters on the wall, information in booklets and in staff training.</p> <p>Raeburn Rest Home is part of Oceania Healthcare Limited (Oceania) with the executive management team providing support to the service. The clinical manager (CM) and BCM are both new to their roles, and have both been appointed since the previous audit. The CM started in the role in January 2017 and has 20 months experience in aged residential care; their previous experience has been in acute nursing services. The BCM, who is also new to the role, has a business management background, and has been in the position for three months. The CM and BCM were supported by the senior clinical and quality manager (SCQM) during the on-site audit.</p> <p>The clinical care service is overseen by the CM, who is a registered nurse (RN). Both the BCM and the CM attend study days and additional training and education specific to management. HealthCERT have been informed of the new CM appointment at the facility.</p> <p>The facility can provide care for up to 54 residents with 39 beds occupied at audit. This included 16 residents requiring rest home level care, 13 residents requiring hospital level care and 10 residents in the dementia unit. These numbers included one resident at hospital level care identified as being under the young people with disability contract. Other contracts that the service had with the WDHB are for residential respite services and long-term chronic care services.</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</p>	<p>PA Low</p>	<p>The service uses Oceania's quality and risk management framework. This framework is documented to guide practice and to minimise risks to residents, staff and visitors. Quality and risk issues are discussed at facility's meetings.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies and procedures are current, reflect best practice, meet legislative requirements and are reviewed regularly as defined by policy. When policies are updated or changed, or new policies introduced, these are distributed to staff to read and sign to confirm they have read and understood the new policy. The document control system ensures that obsolete documents are removed from use. Staff stated they are informed of new and revised policies.</p>

improvement principles.		<p>The service has an internal auditing programme that covers service delivery. Regular audits are undertaken and corrective action planning put in place to manage shortfalls identified. The 2017 resident satisfaction survey shows satisfaction with services provided. This was confirmed by resident interviews.</p> <p>The service has a documented health and safety programme, which includes managing hazards, reporting and investigating accidents, planning for emergencies, and health and safety education to ensure staff, visitors and contractors meet the standards. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed and risks minimised or isolated.</p> <p>Processes are implemented to manage incidents and accidents as verified in documentation reviewed and interviews with staff, residents and family interviewed.</p> <p>The key components of service delivery, reviewed during the audit, had not consistently been linked to the quality management system.</p> <p>The previous requirement for improvement relating to meeting minutes having to include all aspects of the quality and risk management programme has been implemented.</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>	FA	<p>The BCM and CM understand their obligations in relation to essential notification reporting and know which regulatory bodies must be notified. Excluding new management notification, there have been no other events that have required essential notification to the appropriate authorities.</p> <p>The incident/accident reporting processes are documented and corrective actions to be taken are shown on the forms used by the service. Management confirmed that information gathered from incident and accidents is used as an opportunity to improve services where indicated (refer to 1.2.3.6). Corrective action plans to address areas requiring improvement were documented on accident/incident forms sighted.</p> <p>Staff stated they report and record incidents and accidents, and this information is shared at all levels of the organisation, including any follow up actions required being reviewed at facility meetings. Residents' files evidenced staff are documenting adverse, unplanned or untoward events on accident/incident forms. The RNs undertake assessments of residents following an accident/incident. This is recorded on an accident/incident form and in the resident's clinical file.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes</p>	FA	<p>Staff that require professional qualifications have them validated as part of the employment process. Annual practising certificates were signed for all staff and contractors who require it. Staff undertake training and education related to their appointed roles. The serviced currently have three interRAI trained RNs; the CM and two RNs who have resigned from the service as of end of October 2017 (refer to 1.2.8.1).</p>

<p>are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>Written policies and procedures in relation to human resource management are documented. Management stated that staff complete an orientation programme which covers the essential components of health and safety and service delivery, with specific competencies for their roles. Completed orientation booklets were sighted in all staff files reviewed. Newly appointed staff are police vetted upon employment and referees are checked. Job descriptions clearly describe staff responsibilities and best practice standards. These were sighted in staff files reviewed. An appraisal schedule is in place and current staff appraisals were sighted in the staff files.</p> <p>The in-service education programme and the core study days were reviewed and evidence staff education is provided to all staff. Core study days are provided for RNs, healthcare assistants (HCA) and non-clinical staff, with mandatory education and training in the areas relevant to their level of responsibilities and authority. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided. Competency assessments could not be verified for all staff/RNs (refer to 1.3.12.3).</p> <p>The staff working in the dementia unit have completed or are currently enrolled in specific training relating to dementia. The previous requirement for improvement relating to staff working in the dementia unit having to be enrolled for specific dementia care training has been implemented.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Moderate</p>	<p>Oceania policies identify staffing levels and skill mix to meet residents' needs and to comply with the DHB's contractual requirements and safe staffing guidelines. However, there have been five RN resignations during the period of July and August 2017. After these resignations, the facility has been functioning with the CM, two experienced RNs working full time and casual, inexperienced and new graduate RNs. During the week of the audit the two experienced RNs both resigned effective this month (October 2017) which leaves the facility with mainly part time RNs with little experience in aged residential care.</p> <p>During the on-site audit, in order to mitigate the risk for the organisation, with the additional resignations of the two experienced staff the organisation put a staffing risk management plan in place (across all shifts, including night shift). The portfolio manager at the DHB was informed post audit and provided with a copy of the staffing risk management plan to ensure support for the service, as advised by HealthCERT at the time of the audit. The staffing risk management plan demonstrates how the service will ensure RN cover is in place over the next four weeks while the service works with the DHB to determine a long-term plan which includes recruiting an experienced RN to support effective and safe clinical management of the service. The plan did not include a plan for on-call duties, however, the DHB has been informed of the need to include on-call arrangements.</p> <p>Staff, resident and family interviews confirmed the need for experienced RNs.</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>PA Moderate</p>	<p>The computerised medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. The medication entries sampled on the electronic system complied with legislation, protocols and guidelines. Medications are stored in a safe and secure way. The e-prescribing electronic system is accessed by secure individualised staff passwords. . All medications are reviewed every three months and as required by the GP.</p> <p>An annual medication competency is completed for staff administering medications and medication training records were sighted. Three of the four recently employed RNs administering medicines did not have current medication competencies. The medication errors are recorded on accident/incident forms, however, they are not consistently entered into the key performance indicator data (refer to 1.2.3.6).</p> <p>There was one resident self-administering medication at the time of the audit and they did so according to policies and medication guides.</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>PA Low</p>	<p>The food services are prepared on site and served in the respective dining areas. The Oceania seasonal menu has been reviewed by a dietitian. The Oceania menus provide choices for residents with meal selection, however, this is not provided for the residents at this facility, confirmed by the cook, management and residents' interviews.</p> <p>The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes, however, these are not consistently reassessed (refer to 1.3.3.3). The CM stated the initial nutritional profiles and the reassessed profiles are communicated to the kitchen staff, however, upon review of the residents' nutritional profiles in the kitchen this was not evidenced. The interview with the cook confirmed their awareness of a number of modified diets required, however, individual residents' food requirements could not be identified.</p> <p>The resident's weight is monitored regularly and supplements are provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all decanted food containers. The records of temperature monitoring on fridges and freezers are maintained. Food temperatures are taken and recorded. Regular cleaning is undertaken and all services comply with current legislation and guidelines.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive</p>	<p>PA Moderate</p>	<p>The documented interventions do not consistently reflect the residents' assessed needs as identified by initial risk assessments and risk reassessments. The progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies were observed and the staff</p>

adequate and appropriate services in order to meet their assessed needs and desired outcomes.		confirmed they have access to the supplies and products they need.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Interviews with the diversional therapist (DT) and the activities coordinator (AC) confirmed they plan, implement and evaluate the activities programmes at the facility. There is one activities programme for the rest home and hospital residents and one activities programme for the residents with dementia. The activities programmes provide access to activities relating to the physical, social, recreational, emotional and cultural needs of the residents. The activities staff reported that they modify activities based on the residents' responses and interests and according to the capability and cognitive abilities of the residents.</p> <p>Both the DT and the AC work Monday to Friday. The after-hours and weekend activities in the dementia unit are provided by the HCAs. There was evidence of residents' participation in after-hours and weekend activities. The residents were observed to be participating in meaningful activities on audit days. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided.</p> <p>Residents' meetings provide a forum for discussion relating to activities. The activities staff stated the family members are notified of the upcoming residents' meetings and invited to attend.</p> <p>The activities assessments are completed within the required timeframes. The activities assessments sighted recorded the residents' past and present interests and abilities and recreational requirements. The activities care plans reviewed recorded the individual interests of the residents and their abilities to be involved in the activities programmes. The residents with dementia had additional activities care plans that describe how the resident's behaviour is best managed over a 24 hour period. The activities staff review the residents' attendance and participation in the activities provided and record this in the monthly activities progress notes. The areas identified as requiring improvement at the previous audit are met.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' long-term care plans and interRAI assessments are evaluated at least six-monthly (refer to 1.3.6.1). Residents, relatives and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short-term care plans are developed when needed and signed off and closed out when the short-term problem has resolved.</p>
Standard 1.4.2: Facility	FA	<p>The building warrant of fitness is current. The CM stated there have been no alterations to the buildings since the last certification audit. Visitors use call bells to summon staff or physically call out when they need</p>

<p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>assistance.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Interviews with the infection control nurse (ICN) and the CM confirmed the infection data is collected, analysed and reported monthly. The reports are shared with management, staff and the Oceania support office. This information is reviewed by the Oceania clinical quality team and reported to the Oceania board monthly.</p> <p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Staff interviewed reported that they are informed of infection rates at facility's meetings and through compiled reports. The clinical files of residents who were treated for infections evidenced short-term care plans were completed for the short-term problems.</p> <p>In interview, the ICN confirmed no outbreaks have occurred at the facility since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The Oceania restraint minimisation policy and procedures include methods for minimising restraint and approved alternatives. The definitions of restraints and enablers are consistent with the standards.</p> <p>Staff complete a restraint minimisation competency during orientation. There is mandatory ongoing education and training in restraint minimisation.</p> <p>There was one resident requesting the use of an enabler and three residents assessed as requiring restraints. The review of the clinical files evidenced the processes of assessments, consent, care planning, monitoring and review for both enablers and restraints are conducted according to the standards and Oceania policy. The assessment, approval, monitoring and review process is the same for both restraints and enablers.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	<p>Incident and accident records are recorded, family notified and corrective actions are implemented. The records reviewed showed evidenced specific corrective actions with specific individuals identified to implement the changes. Once corrective actions are implemented, the clinical manager signs off the corrective actions and the BCM reviews and closes out the corrective actions</p> <p>Not all data for a number of incidents and accidents has been entered into the quality system. These records include key quality indicators, which therefore have not been included in data benchmarked, monitoring and analysing trends.</p>	Incident and accident data, including medicines management issues, skin tears and a pressure injuries, were not included in the key quality indicators entered into the facilities quality system.	<p>All incident and accidents (quality improvement data) to be collected, analysed, evaluated and communicated.</p> <p>180 days</p>

<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>Review of the rosters showed that all RN shifts at the time of the on-site audit were covered, however, some of the shifts were covered by new graduate and inexperienced RNs. Of the five RNs included in the roster, two have resigned. One of the RNs is leaving within the following two weeks and the other at the end of the month. It is anticipated that the staffing skill mix by the end of October 2017 would increase the current on-site audit moderate risk rating to high risk. To mitigate the risk, the facility developed a staffing risk management plan during audit days to ensure sufficient RN provision. HealthCERT and the Waikato DHB portfolio manager have been informed. The CM, with the help of senior nurses, has been responsible for on-call in relation to clinical issues. With the experienced staff leaving, the CM will need assistance in managing on-call.</p>	<p>Provisional rosters, review of resident files, and interviews confirmed a lack of suitably skilled and experienced RN cover at the facility, including on-call.</p>	<p>Ensure suitably skilled and experienced RN cover is provided, including appropriate on-call services.</p> <p>30 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Moderate</p>	<p>There are RNs and HCAs who administer medicines at the facility. The CM stated all staff undergo annual medication competency tests and these are current. Interview with a HCA who administered medicines during on-site audit confirmed they had current medication competency. New RNs employed at the facility have undergone orientation relating to medication management, however, three of the four RNs' medication competencies reviewed could not be verified at the time of the audit.</p>	<p>Not all staff who administer medicines could verify current medication competencies.</p>	<p>Ensure all staff who administer medicines have current medication competencies.</p> <p>30 days</p>
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	<p>PA Low</p>	<p>The Oceania company-wide menu has choices for the residents to make in respect of their food likes, dislikes and preferences. The interview with the cook confirmed in the past the residents were given the option to choose the meal from the menu, however, this had been discontinued at this facility.</p> <p>The review of the residents' dietary profiles in the kitchen evidenced that a number of the dietary profiles were not current. The nutritional profiles in the kitchen folder were of past residents or were out of date and the new residents did not have their profiles in the kitchen.</p> <p>The dietary summary of the residents' meal sizes, likes and dislikes, food allergies</p>	<p>i) The residents' nutritional profiles could not all be verified in the kitchen and not all were current.</p> <p>ii) The residents were not offered meal choices in</p>	<p>i) Ensure all residents' nutritional profiles are current and communicated to the kitchen staff.</p> <p>ii) Ensure residents are</p>

		is not current, last reviewed in January 2017.	relation to meal preference, likes and dislikes.	provided with meal choices in relation to meal preference, likes and dislikes. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	<p>Seven residents' clinical files were reviewed and comprised of four tracer methodologies (two rest home, one hospital and one dementia) and three additional files (one rest home, one hospital under 65 years of age and one dementia clinical file). Following identification of non-conformities the sample size was widened to two rest home residents' files. The additional two rest home clinical files review related to: initial care plans; initial risk assessments; risk reassessment; GP initial assessments; long-term care plan timeframes and interRAI assessments.</p> <p>Review of clinical files evidenced:</p> <ul style="list-style-type: none"> i) One resident with dementia (tracer methodology), who was assessed as having a pressure injury, did not have timely pressure injury treatment and preventative measures commenced. ii) In review of two residents with wounds, the assessments and treatments were not consistently conducted according to the timeframes stated. iii) Two residents' files identified the GP initial assessments were not completed within the required timeframe. v) Four of the clinical files evidenced the interRAI assessments were not completed within 21 days of admission to the facility. vi) Three files evidenced the long-term care plans were not completed within the 21 days of admission. vii) Three files did not have the required initial risk assessments or risk reassessments completed. 	The service provision timeframes are not consistently adhered to.	Provide evidence each stage of service provision is provided within the required timeframes. 90 days

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Four of the residents' clinical files evidenced the initial care plans were incomplete.</p> <p>Two of the clinical files evidenced the risk assessment findings were not reflected in the residents' long-term care plans.</p>	<p>Risk assessment outcomes were not consistently recorded in the initial and long-term care plans.</p>	<p>Ensure risk assessments outcomes are reflected in the initial care plans and the long term care plans.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.