# Radius Residential Care Limited - Radius Matua Lifecare

## 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 Health and Disability Auditing New Zealand 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Radius Residential Care Limited

**Premises audited:** Radius Matua Lifecare

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 20 May 2015 End date: 21 May 2015

**Proposed changes to current services (if any):** This audit has assessed four additional rooms in the dementia unit as suitable for use within the dementia unit.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 140

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

## General overview of the audit

Radius Matua is part of the Radius Residential Care Group. Matua cares for up to 153 residents requiring hospital, rest home and dementia level care. On the day of the audit there were 140 residents. There are no residents under the medical aspect of the contract. This audit has assessed the service as able to cater for four extra residents in single rooms within the secure dementia unit.

The facility manager is an experienced manager and has been in the role for six months. The facility manager is supported by a clinical manager, an assistant manager, team leaders and the Radius regional manager.

This unannounced surveillance audit was conducted against a subset of the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management. Residents and family interviewed spoke positively about the service provided.

Two of three previous shortfalls have been addressed. These were around wound management and aspects of medication management including transcribing, administration documentation and three monthly general practitioner (GP) reviews.

Improvement continues to be required around care plan intervention documentation.

This audit identified improvements required around timeliness of documentation, assessments, aspects of medication management including use of stock medication and documenting indications for use for as required medications, safe storage of chemicals and infection control practice.

## 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. |

There is an open disclosure and interpreters policy that staff understand. There is a complaints policy supporting practice and an up to date register. Staff interviews confirmed an understanding of the complaints process.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

There are organisational wide processes to monitor performance. There is a quality system that is being implemented in line with the quality plan. Staff and quality meetings are used to monitor quality activities such as audit, complaints, health and safety, infection control and restraint. There is an adverse event reporting system implemented at and monthly data collection monitors predetermined indicators. There are implemented human resource processes. There is an annual education programme and records of attendance are maintained. There is a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty match needs of different shifts.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

There is comprehensive service information available. Residents are assessed prior to entry to the service. Initial assessments and risk assessment tools are completed by the registered nurses on admission. Registered nurses are responsible for care plan development with input from residents and family. Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

There is a current building warrant of fitness.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

There is a documented definition of restraint and enablers that aligns with the definition in the standards. There are no residents requiring restraint and two residents with enablers. Enabler use is voluntary.

## Infection prevention and control

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| 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. |  | Some standards applicable to this service partially attained and of low risk. |

Matua has an infection control programme that complies with current best practice. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 15 | 0 | 2 | 4 | 0 | 0 |
| **Criteria** | 0 | 41 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Residents and relatives interviewed were familiar with the complaints procedure and stated that all concerns /complaints have been addressed.  The complaints log/register includes date of incident, complainant, summary of complaint and sign off as complete. There have been six complaints in 2015 including three via the health and disability commissioner. Corrective action plans have been implemented following these complaints. All have documentation of full investigation and resolution including communication with complainants documented for all complaints.  A complaints procedure is provided to residents within the information pack at entry.  There is written information on the service philosophy and practices particular to the dementia unit included in the information pack. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure policy. There are monthly resident/relative meetings facilitated by the activities staff allowing residents/relatives to raise issues. Relatives are informed of these by email. Relatives (three from the rest home, three from the hospital and two from the dementia unit) and residents (three from the hospital and six from the rest home) interviewed stated they were welcomed on entry and were given time and explanation about services and procedures.  Eleven incident reports reviewed (April 2015) all recorded family notification. Relatives interviewed confirmed they are notified of any changes in their family member's health status (link HealthCERT letter 1 April 2015).  The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The facility has an interpreter policy to guide staff in accessing interpreter services |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Radius Matua is part of the Radius Residential Care Group. The service provides care for up to 153 residents requiring hospital, dementia and rest home level care. On the day of the audit there were 60 residents receiving rest home level care, 21 residents in the dementia unit and 59 receiving hospital level care. This audit has assessed the dementia unit as able to cater for up to four extra residents in four new rooms.  The facility manager reports monthly to the regional manager on a range of operational matters in relation to Matua including strategic and operational issues, incidents and accidents, complaints, health and safety.  There is a 2015 business plan with specific goals for Matua and achievement toward 2014 goals has been documented.  The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.  The service has a documented structure that supports continuity of management and care delivery. This includes a facility manager, an assistant manager, a clinical manager, team leaders and other staff.  The facility manager has been in the role since November 2014. The assistant manager is an enrolled nurse and has been with the service for many years and the clinical manager (a registered nurse) has been at the service for seven years.  The organisation provides annual conferences for their managers and annual regional conferences. ARC,D17.3di (rest home), D17.4b (hospital), The manager has maintained at least eight hours annually of professional development activities related to managing a hospital. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality system continues to be implemented at Matua. Interviews with eight healthcare assistants (HCA’s) (two from the rest home, one from the dementia unit and five from the hospital), one enrolled nurse and three registered nurses including two team leaders, confirmed that quality data is discussed at monthly HCA and registered staff meetings. There is also a monthly SQIRM (safety, quality, infection control and restraint) meeting where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff.  There are policies and procedures appropriate for service delivery including falls management and wound management (link HealthCERT letter 1 April 2015). Policy manuals are reviewed two yearly. New/updated policies are sent from head office.  Monthly reports by the facility manager to the regional manager are provided on service indicators. Radius benchmarks its own facilities against predetermined indicators that are reported monthly from facilities. The service collects internal monitoring data (internal audits) with the audit schedule being implemented at Matua by the assistant manager. Quality improvement data such as incidents /accidents, hazards, internal audit, infections are collected and analysed/evaluated at the SQIRM meeting. Corrective action plans were developed all audits where there has been less than 95% conformity.  D19.3 There is implemented risk management, and health and safety policies and procedures in place including accident and hazard management.  D19.2g: Falls prevention strategies are implemented such as aggregating data monthly that includes considering time of occurrence. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | D19.3b; There is an accident/incident reporting and open disclosure policy/procedure. Month by month indicator data collection included (but not limited to): falls (no injury, soft tissue, and fractures), skin tears, medication and pressure areas. Aggregation of data is undertaken (monthly summary's sighted) and outcomes are discussed at all meetings - management, SQIRM, HCA and registered staff meetings.  Incident forms sampled evidence that investigations have been conducted following incidents (link HealthCERT letter 1 April 2015). Clinical follow up and care has been provided including neuro-observations following a head injury.  The healthcare assistants and the registered staff interviewed could describe the process for management and reporting of incidents and accidents.  Discussions with the service (regional manager and facility manager) confirms an awareness of the requirement to notify relevant authorities (DHB) in relation to essential notifications. This occurred for a sudden death being investigated by the coroner, and the reporting of an outbreak to appropriate agencies. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Recruitment, selection and appointment of staff policy is in place and implemented. Eight staff files were reviewed and performance appraisals were up to date. Current practicing certificates are kept on file.  Matua has an orientation programme that is specific to worker type and includes manual handling, health and safety in service and competency testing. In the staff files reviewed there was a record that an orientation had been completed.  The service has an internal training programme directed by head office. The training programme has exceeded eight hours in 2014 and has commenced for 2015. The programme is run through study days for staff covering core topics. All in-service education includes a quiz which is used at Matua to embed information from the sessions provided. Challenging behaviour and dementia are part of the training programme.  Registered nurse (RN) competencies include: hand washing, manual handling, restraint, medication and syringe driver. A tracking process is in place to monitor requirements.  There are 12 HCA’s who work in the dementia unit. Seven have completed the required dementia standards and the other five HCA’s are in the process of completing. These five staff members have been at the service for less than one year. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The acuity and clinical staffing ratio policy includes a documented rationale for staffing the service. Staffing rosters were sighted and there were staff on duty to match needs of different shifts. The clinical manager (registered nurse) works full time.  Staff turnover has been at around 30%. The healthcare assistants, enrolled nurse and registered nurses interviewed stated that there is adequate staffing to manage their workload on any shift including the additional four rooms in the dementia unit. There are registered nurses on duty 24 hours per day including one from 12.00 pm to 8.30 pm seven days per week in the dementia unit.  Residents and relatives interviewed confirm that there are sufficient staff on site. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission and assessment policy and processes and resident’s needs are assessed prior to entry. Information gathered at admission is retained in resident’s records. Eight family interviewed stated they were well informed upon admission. The information pack includes all relevant aspects of service and residents and/or family/whānau are provided with associated information such as the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). The service conducts an assessment of needs on entry (and prior to entry where practicable) of a resident to the service (link HealthCERT letter 1 April 2015). |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Medications were evidenced to have been checked against the doctor's medication profile on arrival from the pharmacy by an RN. Any mistakes by the pharmacy are regarded as an incident.  Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. Two registered nurses and one healthcare assistant were observed safely and correctly administering medications.  Resident medication charts sampled were identified with demographic details and photographs. Weekly temperature checks have been completed for medication fridges. All 16 medication charts reviewed evidenced that allergies or nil known allergies were documented.  All medications are stored appropriately.  There is one hospital resident who self-administers medication. A competency assessment has been completed.  Fourteen of sixteen (two residents have been at the service less than three months) medication charts reviewed identified that the GP had seen the resident three monthly and the medication chart was signed. All 16 medication charts indicate medication has been administered as prescribed. Eleven residents in the rest home were noted to being administered as required analgesia from stock medication. Thirteen of sixteen medication charts document the indication for giving the as required (PRN) medication. All eye drops were dated on opening.  The service has addressed the previous audit findings around transcribing, gaps in signing sheets and three monthly reviews by the GP. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The service has a large workable kitchen. The kitchen and the equipment were well maintained. The service employs sufficient kitchen staff to provide meal services over seven days a week. There is a rotating four weekly menu in place that is designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed.  Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented.  The residents interviewed spoke positively about meals provided and they all stated that they are asked by staff about their food preferences.  The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires. All food is stored and handled safely. Food temperatures are recorded. The kitchen is clean.  Kitchen staff have been trained in safe food handling.  The service provides additional nutritious snacks available over 24 hours that are readily available for residents in the dementia unit  The service can cater for an additional four residents in the dementia unit. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | All residents are admitted with a care level needs assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information has been gathered during the admission process to form the basis of resident goals and objectives in the sample of resident files. Assessments were evidenced to have been reviewed at least six monthly in five resident’s files reviewed and appropriate risk assessments were completed for individual resident issues. Eight RNs have completed InterRAI training and the assessment tool was evident in resident files.  Notes by GP and allied health professionals were evident in resident’s files, significant events, communication with families and notes as required by registered nurses. Families interviewed were very supportive of the care provided and expressed that the needs of their family member were being met (link HealthCERT letter 1 April 2015). |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | An initial care plan had been developed within 24 hours in the sample of files reviewed. Service delivery plans (care plans) demonstrated service integration and input from allied health. The long term care plans have been completed within three weeks as evidence in files sampled (# link 1.3.3.3). A GP had admitted the residents within two working days. Five of eight residents' care plans reviewed on the day of the audit provide evidence of individualised support and detailed interventions to meet residents identified needs. This was a previous audit finding that still requires improvement. Residents and family members interviewed confirmed that care delivery and support by staff is consistent with their expectations. Short term care plans were in use for changes in health status and files reviewed identified that family were involved.  Two resident files reviewed in the dementia unit identified current abilities, level of independence, identified needs and specific behavioural management strategies. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management plans were evident. The use of short term care plans were evident. In all files sampled the residents were receiving care that met all their needs. The GP interviewed stated the facility applied changes of care advice immediately and was complimentary about the quality of service delivery provided. Residents' needs are assessed prior to admission and resident’s primary care is provided by the facility GP’s unless the resident chooses another GP.  Dressing supplies are available and a treatment room is stocked for use.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.  Specialist continence advice is available as needed.  Wound assessment and wound management plans are in place for 26 residents (14 hospital, nine rest home and three dementia) with wounds. Five hospital and one rest home residents have a pressure area (grade one and grade two). There is evidence in files of the wound specialist referrals. Wound care is completed within timeframes. This was a previous audit finding that has now been addressed. |
| Standard 1.3.7: Planned Activities  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. | FA | The recreational coordinator is a qualified occupational therapist (OT) and has worked at the service for 14 years. There are three additional activity officers who work in the facility across all service levels. All recreation/activities assessments and reviews were up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge and throughout the facility. Residents have a comprehensive assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family.  Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life.  All residents and family members interviewed stated that activities were appropriate and varied and spoke positively about the programme.  Eight resident files reviewed identified that the individual activity plan is reviewed at the time of the care plan review. Residents in the dementia unit have an activity plan over 24 hours. Healthcare assistants in the dementia unit assist with activities over the weekend and evenings. The programme observed was appropriate for older people with mental health conditions. The programme caters for an additional four residents in the dementia unit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Seven of eight initial care plans in files sampled were developed by an RN within three weeks of admission and evaluated at least six monthly (link 1.3.3.3) or if there is a change in health status. Residents are seen by a GP at least three monthly. Changes in health status were documented in the sample of files reviewed and followed up with exceptions (# link 1.3.5.2). GP's review residents medication at least three monthly or when requested if issues arise or health status changes. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | PA Moderate | There are designated areas for storage of cleaning/laundry chemicals and chemicals. During a tour of the facility it was observed that sluice rooms contained chemicals which were not always locked when not in use. Not all chemicals were labelled with manufacturer labels. Product use charts were available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness.  This audit has assessed four additional rooms in the dementia unit as suitable for use. The rooms are large with two sharing an ensuite and two having individual ensuites. Internal and external communal areas including the dining and lounge areas are adequate to manage the four additional residents. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | PA Low | Radius has an established infection control (IC) programme that is implemented at Matua. The infection control programme has been appropriate for the size, complexity and degree of risk associated with the service and has been linked into the quality management system. The clinical manager is the designated infection control nurse with support from the registered nurses. Infection control matters are discussed at SQIRM meetings. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually. There were toiletries sighted in two communal showers and a communal toilet. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance of infection data assists in evaluating compliance with infection control practices. Infection data has been collated monthly in the records reviewed - including urinary tract, upper respiratory and skin. This data is reported to the SQIRM meetings and also to HCA and registered staff meetings. Monthly data was seen in staff areas. The service submits data monthly to Radius head office where benchmarking is completed. Incidences of a staff member with a communicable disease and two outbreaks in 2014 were well managed. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked.  There is a regional restraint group at the organisational level and a restraint group at the facility where restraint is reviewed.  There are two residents with enablers and none with restraints. Enabler use is voluntary. |

# 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.

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Doctors are responsible for prescribing and 14 of 16 medication charts sampled have been reviewed at least three monthly by the GP (two residents have been at the service less than three months). Thirteen of sixteen charts document the indication for use of prescribed as required medication. Residents are prescribed as required medication by the GP. | (i) Three of sixteen medication charts sampled do not document an indication for use for as required medication. (ii) Eleven residents in the rest home are being administered as required analgesia from stock supplies. | (i) Ensure as required medications document an indication for use. (ii) Ensure residents in the rest home have individual prescribed medication and stock medications are not used.  60 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 Low | The long term care plan was completed within three weeks in seven of eight residents files reviewed (two hospital, three rest home and two dementia). Seven of eight care plans reviewed evidenced evaluations completed at least six monthly (two hospital, three rest home and two dementia). | One hospital resident did not have a long term care plan developed until seven weeks following admission, and evaluation of the care plan was not completed within the six monthly time frame. | Ensure that all residents have a long term care plan and evaluation of the care plan completed within the expected time frame.  90 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | Risk assessments are completed on admission and are intended to be reviewed at least six monthly. Five of eight resident’s files sampled (two hospital, two rest home and one dementia) had risk assessments completed on admission and reviewed six monthly. Risk assessments include but are not limited to; falls risk, pain, pressure area risk, continence and nutrition. | In three of eight residents files sampled (one hospital, one rest home and one dementia,) risk assessments were not reviewed six monthly. | Ensure that all residents have risk assessments reviewed at least six monthly to form the basis of service delivery for each resident.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Five (one hospital, two rest home and two dementia) of eight residents' care plans reviewed on the day of the audit provide evidence of individualised support and detailed interventions to meet residents identified needs. | Three resident files reviewed (two hospital and one rest home) did not have all detailed interventions to meet the resident’s needs. One hospital resident had noted weight loss, had a problem chewing foods and the GP had documented for comfort cares. Interventions have not been updated in the residents care plan. One other hospital resident and one rest home resident both had noted weight loss and both residents care plans do not address this. | Ensure that all resident care plans reflect the residents identified needs and direct staff in residents cares.  60 days |
| Criterion 1.4.1.1  Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Moderate | Chemicals are kept in cleaning rooms in each area which are kept locked. There were also some chemicals in each sluice room. One sluice room had a staff member in it at the time it was sighted. There were three bottles of unlabelled chemicals sighted in the facility. | (i) Three of four sluice rooms with chemicals on shelves were not locked during the facility tour; (ii) Manufacturer’s labels were not evident on all chemical bottles. | (i) Ensure all chemicals are stored securely. (ii) Ensure all chemical bottles have a manufacturer’s label.  60 days |
| Criterion 3.1.1  The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management. | PA Low | HCA’s and registered staff interviewed described appropriate infection control practices around management of infectious symptoms, use of PPE, hand washing and transport of laundry. On a tour of the facility it was observed that communal bathroom facilities had toiletries stored for communal use. | Two communal showers and one communal toilet had resident toiletries stored for communal use. | Ensure that there are no toiletries used for communal purposes or kept in communal areas.  60 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.