

Radius Residential Care Limited - Radius Rimu Park

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](#).

The specifics of this audit included:

Legal entity: Radius Residential Care Limited

Premises audited: Radius Rimu Park

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

Dates of audit: Start date: 26 January 2016 End date: 26 January 2016

Proposed changes to current services (if any): Three rooms previously used for hospital level residents are now being used for the psychogeriatric unit.

Total beds occupied across all premises included in the audit on the first day of the audit: 47



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

Radius Rimu Park is part of the Radius Residential Care Group. Rimu Park cares for up to 53 residents requiring hospital, psychogeriatric and rest home level care. On the day of the audit there were 47 residents. This audit including assessing three rooms, which were previously in the hospital wing and are now in the extended psychogeriatric unit, as appropriate for the intended purpose.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

The facility manager is a registered nurse and has been in the role for two years. She is supported by a clinical nurse manager and the Radius regional manager.

Residents and family interviewed spoke positively about the service provided.

Neither of the two shortfalls identified at the previous audit has been addressed. The previous findings around meeting minutes and care interventions remain.

This surveillance audit identified that improvements are required in relation to the review of facility goals, corrective action planning, essential notifications, staff inductions, reference checks, staff training around dementia care, registered nurse cover, interRAI assessments, timeliness of care plans, progress notes, activities plans and attendance record and medication management.

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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There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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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Services are planned, coordinated, and are appropriate to the needs of the residents. A facility manager and clinical nurse manager are responsible for the day-to-day operations of the facility. Quality and risk management processes are established. Adverse, unplanned and untoward events are responded to in an appropriate and timely manner. An orientation programme is in

place for new staff. An education and training programme for staff is underway. There are sufficient healthcare assistants rostered to meet resident's needs.

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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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. Staff who administer medications are competent to do so. 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

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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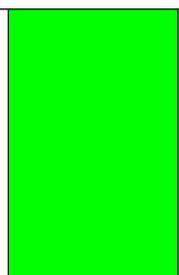
A current building warrant of fitness is posted in a visible location. The psychogeriatric unit has been extended to include three rooms previously in the hospital area.

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 service has alternative systems available so that staff can use restraint as a last resort strategy. There were nine residents using restraints and two hospital level residents voluntarily using bedrails as enablers on the day of the audit. Care plans include reference to the use of enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Rimu Park 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.

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	7	0	4	5	0	0
Criteria	0	26	0	7	6	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 service has a complaints policy that describes the management of the complaints process. Complaints forms are accessible to residents and family. Information about complaints is provided on admission. Interviews with five residents (two hospital level and three rest home level) and family members confirmed their understanding of the complaints process. Care staff interviewed (three health care assistants, four registered nurses, one diversional therapist and one activities coordinator) were able to describe the process around reporting complaints.</p> <p>The complaints register included verbal and written complaints with evidence to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, meeting time lines, corrective actions when required, and resolutions.</p> <p>Sixteen complaints received in 2015 (year to date) were signed off as resolved. Two of these complaints were reviewed in detail reflecting evidence of the complaints being managed within the required time frames as determined by the Health and Disability Commissioner (HDC). Two complaints lodged in 2016 are currently under investigation. One of these two complaints received has been referred to HDC although the facility manager has yet to be formally notified by HDC.</p>
Standard 1.1.9:	FA	An open disclosure policy describes ways that information is provided to residents and families. The admission

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay that is not covered by the agreement. Regular contact is maintained with family including if an incident or care/ health issues arises. Two families interviewed (one at psychogeriatric level and one at rest home level) stated they were kept well informed. Twelve incident/accident forms were reviewed and identified that the next of kin were contacted or if not, justification as to why. Residents' meetings are held three-monthly.</p> <p>The service can access interpreter services through the district health board. The information pack is available in large print and can be read to residents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</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>PA Low</p>	<p>Radius Rimu Park provides rest home, hospital and psychogeriatric levels of care for up to 53 residents in the care centre. On the day of the audit there were 47 residents with 9 at rest home level, 18 at hospital level and 20 at psychogeriatric level of care. All residents' rooms in the rest home and hospital are dual purpose. Forty-six residents were on the Aged Related Care Contract (ARCC) with one hospital-level resident receiving palliative care under the medical component of this contract. One resident (hospital level) was under the Long Term Care Chronic Conditions Contract (LTCC).</p> <p>The facility manager is a registered nurse (RN) and has been employed at the facility for two years. She has worked in the aged care industry for ten years, which includes various management roles. The facility manager reports directly to the regional manager on a range of operational matters in relation to Rimu Park including strategic and operational issues, incidents and accidents, complaints, and health and safety. The clinical nurse manager is a registered nurse who has been employed for two years and has been in her role for one year.</p> <p>The facility's business plan for 2015 is linked to the Radius Care Group strategies and business plan targets. The mission statement is included in information given to new residents. A comprehensive list of goals were documented for 2015. Only a selection of these goals were evidenced to have been reviewed. Goals are being developed for 2016.</p> <p>The facility manager holds minimum of eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>PA Low</p>	<p>A quality and risk management system has been established. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Policies and procedures have been updated to reflect implemented interRAI procedures.</p> <p>Quality data is collected, and collated. A resident satisfaction survey is conducted each year. Results have not</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>yet been received from head office. An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified but there is a lack of evidence to verify that these corrective actions were implemented and evaluated. Staff meeting minutes fail to reflect adequate detail about the quality and risk management programme. This area previously identified for improvement remains.</p> <p>Falls reduction strategies include staff knowing the residents who are at risk, managing challenging behaviours, adhering to residents' routines and anticipating their needs.</p> <p>Processes are in place for accident and incident reporting, injury prevention and management, workplace inspections, and hazard management. The organisation has achieved tertiary level ACC Workplace Safety Management Practice (WSMP).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Low</p>	<p>The service collects data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality and risk management programme (link to findings 1.2.3.6 and 1.2.3.8). Once incidents and accidents are reported, the immediate actions taken are documented on incident forms. The incidents forms are then reviewed and investigated by the registered nurse. If risks are identified these are processed as hazards using a hazard identification form.</p> <p>A discussion with the facility manager failed to confirm her full awareness of statutory requirements in relation to essential notification.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Job descriptions are documented for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of health professionals were current. Seven staff files were reviewed with an expanded sample size (three registered nurses and four health care assistants). Employment practices did not include reference checking in any of the seven staff files. Signed employment contracts, and job descriptions were evident in the sample of staff files. Evidence of completed orientation programmes were missing in a selection of healthcare assistant files. Interviews with care staff described the orientation programme that includes a period of supervision. Annual performance appraisals for staff were completed.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented and attendance is recorded. A minimum of one care staff is available 24/7 with a current first aid/CPR certificate. Not all healthcare assistants working in the psychogeriatric unit has completed the required dementia qualification. Only three of fifteen registered nurses have completed their interRAI training.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The facility manager and clinical nurse manager are registered nurses. A minimum of two staff RN are scheduled 24 hours a day, seven days a week although there have been gaps in registered nursing cover (link 1.2.4.2). In addition to the RNs, there are a minimum of two HCA's rostered with an additional HCA staffed in the absence of an RN.</p> <p>Two activities staff, which includes one diversional therapist, are onsite Monday – Friday.</p> <p>Families and residents interviewed advised that they felt there was sufficient staffing. The roster is able to be changed in response to resident acuity.</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>Medications are 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.</p> <p>Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. A registered nurse was observed safely and correctly administering medications.</p> <p>Resident medication charts are identified with demographic details and seven of the ten sampled had photographs. Allergies were documented. Daily temperature checks have been conducted for the medication fridges. Not all eye drops are dated when opened. Weekly checks of controlled drugs have not always occurred.</p> <p>All medications are stored appropriately.</p> <p>There is one resident who self-administers medication. A competency assessment has been completed.</p> <p>Eight of ten (two residents had been at the service less than three months) medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. Not all medication charts indicated that medication has been administered as prescribed. All medication charts document the indication for giving the PRN medication.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are</p>	<p>FA</p>	<p>The service has a large workable kitchen. The kitchen and the equipment are 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.</p> <p>Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented.</p>

<p>met where this service is a component of service delivery.</p>		<p>The residents interviewed spoke positively about meals provided and they all stated that they are asked by staff about their food preferences. Additional food and snacks are available at all times.</p> <p>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.</p> <p>Kitchen staff have been trained in safe food handling.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management plans were evident. Two hourly turning charts are accurately documented. This is an improvement since the previous audit. The use of short term care plans was evident. In one of five files sampled the residents are receiving care that meets all their needs but not all needs are documented in the care plan. This aspect of the previous finding continues to require improvement. The GP interviewed stated the facility applied changes of care advice immediately and was complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission and resident's primary care is provided by the facility GPs unless the resident chooses another GP.</p> <p>Dressing supplies are available and a treatment room is stocked for use.</p> <p>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.</p> <p>Specialist continence advice is available as needed.</p> <p>There are 16 current wounds including two chronic ulcers, minor wounds and seven pressure injuries (link 1.3.3). Wound assessment and wound management plans are not in place for every wound and timeframes are not always documented and adhered to. There is evidence in files of the wound specialist referrals.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the</p>	<p>PA Low</p>	<p>There is a diversional therapist who provides activities in the rest home/hospital and an activities coordinator who has completed dementia training and who provides activities in the psychogeriatric unit. In files sampled all recreation/activities assessments and reviews are up to date. However, attendance at activities is not recorded. In the psychogeriatric unit activities are planned and documented monthly. Many activities in the hospital/rest home recur at regular times at resident's request. The week's activities are written on the chalk board in the lounge. However, there is no forward plan and no record of previous activities. On the day of audit, residents in both units were observed being actively involved with a variety of activities in the main lounges. 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.</p>

<p>service.</p>		<p>Activities provided are meaningful and reflect ordinary patterns of life. Healthcare assistants provide activities when the activities coordinator is not on duty.</p> <p>All residents and family members interviewed stated that activities are appropriate and varied and spoke positively about the programme.</p> <p>Three of five resident files reviewed identified that the individual activity plan is reviewed at the time of the care plan review. The other two residents are new to the service.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans are evaluated by the registered nurses within three weeks of admission. The long term care plan is evaluated at least six monthly or earlier if there is a change in health status. There is at least a three monthly review by the GP. All changes in health status are documented and followed up (with one exception – link 1.3.6.1). Care plan reviews are signed by an RN. Short term care plans are evaluated and resolved or added to the long term care plan if the problem is on-going as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location (expiry date 1 June 2016).</p> <p>Three additional residents' rooms in the psychogeriatric unit were assessed as suitable at the previous audit but a secure door was yet to be installed. The installation of this secure door has been completed.</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>The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory and skin. This data is reported to the facility meetings. Monthly data was seen in staff areas. The service submits data monthly to Radius head office where benchmarking is completed. There have been no outbreaks since the previous 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 use of restraint 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 designated restraint coordinator/RN at the facility.</p> <p>There were nine residents using restraint (including one environmental restraint) and two residents with enablers in the form of bed rails in the hospital. These were requested by the residents. The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of one of the files of a resident using an enabler.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	A comprehensive list of business goals were developed for 2015 but only a selection of these goals indicate that they were regularly reviewed.	Only a selection of facility goals indicated that they had been reviewed in 2015.	<p>Ensure all business goals are regularly reviewed throughout the year.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated</p>	PA Low	Adverse event data (e.g., falls, skin tears, staff accidents, pressure injuries, infections) data is collected, and collated. Meeting minutes fail to reflect the consistent analyses of data with results being communicated to staff.	Staff meeting minutes fail to reflect adequate detail being communicated to staff regarding the quality and risk management programme.	Ensure staff are kept informed regarding quality and risk management results and

to service providers and, where appropriate, consumers.				corrective actions plans. 90 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	Corrective action plans were documented where opportunities for improvements were identified. Missing was documented evidence of these corrective actions plans being implemented and evaluated.	Although comprehensive corrective actions plans have been developed, there is no evidence to suggest that these corrective action plans have been implemented and evaluated.	<p>Ensure documentation reflects the implementation and evaluation of corrective action plans.</p> <p>90 days</p>
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Low	The facility manager is aware to contact the Ministry of Health in the event of any serious complaint/incident or infectious outbreak but was unaware that the Ministry must also be notified if police are contacted, or that the DHB are to be contacted if registered nursing shifts are not able to be covered (link 1.2.8.1). There was an example given of a wandering resident that required police to be contacted but the Ministry was not informed.	The facility manager was unaware of all obligations in regards to essential notifications. Specifically two recent events which required notification to a relevant authority: a) The Ministry of Health were not notified when police were contacted to assist with an adverse event; and b) the DHB were not notified (as per ARC contract) with regard to the inability to provide registered nurse cover for hospital residents for three recent shifts.	<p>Ensure that the facility manager is fully aware of all conditions that require essential notification and that this occurs when required.</p> <p>90 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Moderate	Staff files contain evidence of the recruitment process, which includes a formal interview. Applicants undergo police vetting but no files reflected evidence of reference checking, even when police vetting results reflected a positive result.	There was no evidence to support reference checking for new applicants in all seven staff files randomly selected for review. All new employees are required to undergo the police vetting process. There was evidence of two employees with positive police reports, one of which involved a vulnerable person and no	<p>Ensure reference checks are completed for potential candidates with more</p>

			evidence of any further reference checks for these two employees.	robust checks for any applicants who identify as potential risks. 30 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	New staff undergo an orientation programme that covers both general and job specific duties. Evidence of completed orientation checklists were sighted in all three RN staff files but not in healthcare assistant files.	Two out of four healthcare assistant staff files reviewed reflected evidence of completed orientation. The healthcare assistants interviewed reported that they all completed an induction programme, which includes a period of supervision, but orientation documentation did not support this.	Ensure staff files reflect evidence of staff completing their orientation programme. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	An education and training schedule is in place for staff that includes both mandatory and job specific education. There has been high turnover in the psychogeriatric unit with thirteen new healthcare assistant (HCA) staff employed in the unit over the past year. Although all healthcare assistant staff who have been employed for over six months are enrolled and have begun work on their dementia qualification, only one of three staff who have been employed for over one year has achieved the dementia qualification.	The psychogeriatric unit is staffed with fourteen regular healthcare assistants and four casual health care assistants. Only one of three HCA staff, who have been employed for over one year, has completed the required dementia qualification. The remaining fifteen staff have been employed for less than one year.	Ensure that all care staff (HCA's) who have been employed for over one year, have completed a dementia qualification. 60 days
Criterion 1.2.8.1 There is a clearly	PA Moderate	A minimum of one RN is rostered in the rest home/hospital with another RN in the psychogeriatric unit at all times. When the	A registered nurse was unavailable during three evening shifts in the rest home/hospital just prior to the audit (Friday – Sunday). The facility	Ensure both the rest home/hospital

<p>documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>		<p>healthcare assistants were queried regarding RN cover, it was discovered that during the previous three evening shifts (Friday – Sunday) the RN scheduled to cover the rest home/hospital was unavailable. A senior HCA filled the RN role with the RN in the psychogeriatric ward covering the entire facility.</p> <p>Healthcare assistant staffing meets contractual obligations. Laundry services are outsourced. Separate cleaning staff are employed. Residents and family reported that staffing levels were adequate.</p>	<p>manager reported that she filled this RN position with a senior caregiver which does not meet contractual requirements. The RN in the psychogeriatric ward covered the entire facility over this period of time.</p>	<p>and psychogeriatric units each have a registered nurse rostered on 24/7.</p> <p>30 days</p>
<p>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.</p>	<p>PA Moderate</p>	<p>Registered nurses interviewed were aware that eye drops should be dated when they are opened. This had not always occurred. Photographs were available of seven of ten medications charts sampled and allergies were documented on nine of ten. Administrations records document that four of ten residents have had all prescribed medications administered. Two residents have been administered enemas that were not prescribed.</p>	<p>(i) Controlled drug weekly checks have not always occurred in the hospital.</p> <p>(ii) There are 11 bottles of open eye drops that have not been dated when opened in the hospital.</p> <p>(iii) Six of ten administration records sampled do not have all prescribed medications signed as administered.</p> <p>(iv) Two residents have been administered enemas that were not prescribed.</p> <p>(v) Three of ten medication charts sampled did not have photographs for identification.</p>	<p>(i) Ensure controlled drug weekly checks are completed.</p> <p>(ii) Ensure all eye drops are dated when they are opened.</p> <p>(iii) Ensure all medications are signed for when administered.</p> <p>(iv) Ensure only prescribed medications are administered.</p> <p>(v) Ensure</p>

				there is photographic identification on all medication charts. 30 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>The registered nurses interviewed were familiar with contractual timeframes around care plans and three of five care plans sampled had care plans developed within 21 days of admissions. The regional manager reports that the service has had difficulty accessing training around interRAI requirements and there are three registered nurses who are interRAI trained. All residents had a comprehensive suite of paper based assessments completed within 21 days of admission but not interRAI assessments.</p>	<p>(i) Two of five resident files sampled (one psychogeriatric and one hospital) did not have the long term care plan completed within 21 days of admission.</p> <p>(ii) Two of five files sampled (one psychogeriatric and one hospital) were for residents admitted since 1 July 2015. Neither had an interRAI assessment completed.</p>	<p>(i) Ensure contractual timeframes around care planning are adhered to.</p> <p>(ii) Ensure new residents have an interRAI assessment completed within the required timeframe.</p> <p>30 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Low</p>	<p>Progress notes are documented by healthcare assistants at least every shift and regularly by registered nurses. Of five randomly selected incidents for January 2016, four were documented in progress notes.</p>	<p>A recent significant incident was not documented in the residents' progress notes.</p>	<p>Ensure all incidents are documented in the progress notes.</p> <p>60 days</p>

<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>Staff interviewed are familiar with behaviour management techniques and resident's needs. Needs are not always documented in care plans. There are wound documentation forms available to complete assessments, plans and reviews. These are not well utilised.</p>	<p>(i) Four of five resident files sampled do not have interventions documented for all identified needs. Examples include hoist use (hospital resident), behaviour management (psychogeriatric unit), medical conditions (rest home) and falls, epilepsy and comfort cares (psychogeriatric unit).</p> <p>(ii) Wound management issues are as follows: (a) one resident with two pressure injuries had these both documented on the same form. (b) Five of 16 wounds (including two pressure injuries) do not have a sufficient assessment documented. One further pressure injury does not have a grade documented. (c) Four of 16 wounds do not have a documented management plan. (d) Six of sixteen wounds (including four pressure injuries) have not been reviewed within the stated timeframes. A further three wounds do not have timeframes for reviews documented.</p>	<p>(i) Ensure all identified needs are addressed in care plans.</p> <p>(ii) Ensure each wound has a comprehensive assessment and management plan, a timeframe for review and that wounds are reviewed within the stated timeframes.</p> <p>30 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>In the psychogeriatric unit activities are planned monthly and documented. The activities coordinator reports that there is flexibility within the programme to accommodate resident's needs at any given time. In the hospital residents request a number of regular activities that occur weekly. Activities for the week are documented on the chalkboard in the lounge. There is no forward plan documented and no record kept of activities provided. Attendance of residents at activities is not documented. Regular reviews of activities plans occurs.</p>	<p>(i) There is no documented forward plan for activities in the rest home/hospital, or record of activities previously provided.</p> <p>(ii) Attendance of residents at activities is not documented.</p>	<p>(i) Ensure a plan for activities is developed and that these are kept to provide a record.</p> <p>(ii) Ensure daily attendance at activities is documented.</p>

				90 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.