**Radius Residential Care Limited - Radius Peppertree Care Centre**

**Current Status:** **25-Jul-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.**

**General overview**

Radius Peppertree is certified to provide rest home and hospital care for up to 60 residents. On the day of the audit there were 57 beds occupied including 25 hospital residents and 32 rest home residents.

The manager has experience in an aged care service and has been with Radius Peppertree for one week. The regional manager has been supporting the service for two and a half months following the resignation of the previous manager.

Thirteen of the 16 shortfalls identified at the previous surveillance audit have been addressed including: complaints, discussion of quality data, orientation and training, restraint competencies, timeliness of GP access, handovers, care plan interventions, care plan evaluations, and medication management.

Improvements continue to be required around corrective action plans, incident documentation, wound documentation and care plan assessments.

This audit also identified further improvements required around open disclosure, performance appraisals, infection control and staffing.

**Audit Summary AS AT** **25-Jul-13**

Standards have been assessed and summarised below:

**Key**

| **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 |

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| **Consumer Rights** | Day of Audit  25-Jul-13 | Assessment |
| 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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Organisational Management** | Day of Audit  25-Jul-13 | Assessment |
| 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 low risk** |

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| **Continuum of Service Delivery** | Day of Audit  25-Jul-13 | Assessment |
| 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 low risk** |

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| **Safe and Appropriate Environment** | Day of Audit  25-Jul-13 | Assessment |
| 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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| **Restraint Minimisation and Safe Practice** | Day of Audit  25-Jul-13 | Assessment |
| 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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| **Infection Prevention and Control** | Day of Audit  25-Jul-13 | Assessment |
| 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** |

**Radius Peppertree Care Centre**

Radius Residential Care Limited

Surveillance audit - Audit Report

Audit Date: 25-Jul-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Radius Residential Care Limited |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Radius Peppertree Care Centre | 107 Roberts Line | Kelvin Grove | Palmerston North |

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| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
|  |

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 25-Jul-13 **End Date:** 26-Jul-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXXX | MBA MN B Ed Adv Dip Child and Family Dip Tchg Lead auditor | 13.00 | 8.00 | 25-Jul-13 to 25-Jul-13 |
| Auditor 1 |  |  |  |  |  |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX |  |  | 2.00 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 13.00 | **Total Audit Hours off site** *(system generated)* | 10.00 | **Total Audit Hours** | 23.00 |
| **Staff Records Reviewed** | 5 of 54 | **Client Records Reviewed** *(numeric)* | 5 of 57 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 5 |
| **Staff Interviewed** | 9 of 54 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 4 |
| **Consumers Interviewed** | 9 of 57 | **Number of Medication Records Reviewed** | 10 of 57 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 2 |

# Declaration

I, (full name of agent or employee of the company) XXXXXXXX (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofHealth and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health and Disability Auditing New Zealand Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 15 day of August 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit: 🗷

The audit summary has been developed in consultation with the provider: 🗷

Electronic Sign Off from a DAA delegated authority (*click here*): 🗷

# Services and Capacity

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|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Radius Peppertree Care Centre | 60 | 57 | 12 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Radius Peppertree is certified to provide rest home and hospital care for up to 60 residents. On the day of the audit there were 57 beds occupied including 25 hospital residents and 32 rest home residents.

The manager has experience in an aged care service and has been with Radius Peppertree for one week. The regional manager has been supporting the service for two and a half months following the resignation of the previous manager. There is a clinical manager who has been previously in the role as a registered nurse. The clinical manager and the regional manager have put in place processes to address any identified areas of need.

Improvements identified at the previous audit have been addressed as follows: to complaints, discussion of quality data, implementation of the audit schedule, monthly reports of incidents and accidents as a true record, documentation of incidents on the incident forms and including these in the monthly collation of data, orientation and training including training around restraint, timeliness of GP access and to handovers, assessments and interventions outcomes are communicated to all, care plans describe the required support and are completed by the RN/ clinical manager, care plan evaluations and review of risk, medication have been addressed. There are continuing improvements required to corrective action plans and review of assessments.

This audit identified improvements required to the following: documentation that family have been informed on the incident report, review of incident forms by the manager/s, performance appraisals, ensuring dressings are changed as per documentation, and staffing.

1.1 Consumer Rights

Residents and family members state they are welcomed on entry and are given time and explanation about services and procedures. Resident meetings occur monthly and the new manager has an open-door policy. There is a complaints register that is up to date and the manager states that this has always identified actions taken. There has been one complaint lodged with the Health and Disability Commission and this is currently being processed.

There is documentation on the family communication form that families are involved in the service and informed of any incidents.

Family and residents interviewed praised the service for the information provided to them in a timely manner.

An improvement identified at the previous audit to complaints has been met.

An improvement is required to documentation that family have been informed on the incident report.

1.2 Organisational Management

Radius Peppertree has a quality and risk management system in place that continues to be implemented and monitored and this generates improvements in practice and service delivery. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. Quality improvement data is analysed to identify trends and themes with benchmarking across Radius sites. This includes incidents, hazards, audits and complaints. A process is implemented to measure achievement against goals in the business plan. The service has an internal audit schedule that is implemented.

There are implemented risk management and health and safety policies and procedures in place including incident, accident and hazard management. There are monthly quality and health safety and staff meetings along with two monthly restraint meetings. The new template for documenting minutes ensures that all aspects of the quality and risk management programme is tabled. ,

Staffing is rostered as per the staffing policy and there is an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes.

Improvements identified at the previous audit relating to discussion of quality data, implementation of the audit schedule, monthly reports of incidents and accidents as a true record, documentation of incidents on the incident forms and including these in the monthly collation of data and orientation and training have been addressed.

There are continuing improvements required to corrective action plans.

There are also improvements required to the following: documentation that family have been informed on the incident report, review of incident forms by the manager/s and performance appraisals, staffing and infection control.

1.3 Continuum of Service Delivery

Registered nurses are responsible for each stage of service provision. The sample of residents' records reviewed provide evidence that the provider has systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and guide all staff in cares. Care plans are reviewed at least six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals.

Medicines are managed and policies reflect legislative requirements. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted.

The activities programme is facilitated by a diversional therapist. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged.

All food is cooked on site by the cooks. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented, homely and the menu plans have been reviewed by a dietician.

There are continuing improvements required to review of assessments.

There are also improvements required to the following: ensuring dressings are changed as per documentation and to MDT meeting.

1.4 Safe and Appropriate Environment

All building and plant have been built to comply to legislation. There is a current building warrant of fitness. The rest home and hospital residents are able to access the building and external environment in a safe manner with rails, wide hallways and safe paths in place.

2 Restraint Minimisation and Safe Practice

There are three residents using bedrails as enablers and six resident using bedrails and/or a lap belt as a restraint. There are processes and registers in place for the use of enablers and restraint and these are implemented with a register maintained. The restraint standards are being implemented and reviewed through internal audits and at an organisational level. Restraint/enabler training and restraint competencies with sign off of practice by the clinical manager is completed annually.

Improvements identified at the previous audit around restraint training have been addressed.

3. Infection Prevention and Control

Infection control data is tabled monthly at the quality and health and safety meetings. Infections are documented on the infection monthly register. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme with benchmarking of data completed across the organisation.

An improvement is required to infection control to ensure that documentation of discussion of data occurs.

Summary of Attainment

* 1. Consumer Rights

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |  | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | PA Low | 0 | 1 | 1 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:10 CI:0 FA: 1 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:0 FA:3 PA:1 UA:0 NA: 0 |

* 1. Organisational Management

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | PA Low | 0 | 7 | 1 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | PA Low | 0 | 1 | 1 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | PA Low | 0 | 3 | 1 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | PA Low | 0 | 0 | 1 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:2 CI:0 FA: 1 PA Neg: 0 PA Low: 4 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:13 PA:4 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | PA Low | 0 | 2 | 1 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:4 CI:0 FA: 7 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:0 FA:16 PA:1 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:7 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:3 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |  | 0 | 0 | 0 | 0 | 0 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 4 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 21): CI:0 FA:4 PA:0 UA:0 NA: 0 |

1. Infection Prevention and Control

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | PA Low | 0 | 1 | 1 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |  | 0 | 0 | 0 | 0 | 0 | 5 |

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| Infection Prevention and Control Standards (of 5): N/A: 4 CI:0 FA: 0 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 29): CI:0 FA:1 PA:1 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 31 **CI:** 0 **FA:** 12 **PA Neg:** 0 **PA Low:** 7 **PA Mod:** 0 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 0 **FA:** 40 **PA:** 7 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Radius Residential Care Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:25-Jul-13 End Date: 26-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

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| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.9 | 1.1.9.1 | PA  Low | **Finding:**  Eight of the 11 incident forms reviewed do not include documentation that family have been informed.  **Action:**  Ensure that the incident form includes documentation of family being informed. | 3 months |
| 1.2.3 | 1.2.3.8 | PA  Low | **Finding:**  Corrective actions are identified where there are findings following internal audit however there continues to be a lack of documentation to indicate that the findings are signed off as being resolved.  **Action:**  Corrective action plans are developed as a result of identified shortfalls. A process to demonstrate on-going monitoring and close out is to be implemented.. | 3 months |
| 1.2.4 | 1.2.4.3 | PA  Low | **Finding:**  The incident forms are not reviewed by the manager/s on three of the 11 incident forms reviewed.  **Action:**  Ensure that all incident forms are reviewed by the clinical manager and/or manager. | 3 months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.2.7 | 1.2.7.5 | PA  Low | **Finding:**  Performance appraisals are not completed annually for all staff.  **Action:**  Complete performance appraisals as per schedule. | 6 months |
| 1.2.8 | 1.2.8.1 | PA  Low | **Finding:**  Nine of nine residents (six hospital and three rest home) and four of four family members including three hospital and one rest home state that there are adequate numbers of staff on duty in the morning however four residents and three family state that bells are not always answered promptly. Residents state that they sometimes wait for half to one hour for someone to come.  **Action:**  Review staffing response to call bells to ensure that residents are supported in a timely manner. | 3 months |
| 1.3.3 | 1.3.3.1 | PA  Low | **Finding:**  i) The frequency of dressing changes is documented for a skin tear (every third day) however the resident has had one dressing change on the third day and the second six days later. ii) Assessments are not reviewed six monthly as per policy. This improvement is identified at the previous audit (1.3.4.1) . iii) The MDT meeting is expected to be held annually however this was last held in May 2012 (note that the clinical manager is already addressing gaps in frequency of MDT meetings).  **Action:**  i) Ensure dressings are changed as per documentation. ii) Ensure that assessments are reviewed six monthly as per policy. The previous improvement required continues (1.3.4.1). iii) Ensure that MDT meeting are held annually. | 6 months |
| 3.5 | 3.5.7 | PA  Low | **Finding:**  i) There is no evidence of discussion around the infection control data collected including discussion after the norovirus outbreak in January 2013. ii) Infections not treated with antibiotics are not included in the surveillance data. iii) The infection control coordinator (registered nurse) states that she has not had training around the role.  **Action:**  i) Evidence discussion around infection control data with documentation that indicates that improvements are made as required. ii) Include infections not treated with antibiotics in the surveillance data. iii) Ensure that the infection control coordinator understands the role and has appropriate education for the role. | 6 months |

# Continuous Improvement (CI) Report

Provider Name: Radius Residential Care Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:25-Jul-13 End Date: 26-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

**1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS**

**OUTCOME 1.1 CONSUMER RIGHTS**

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

**STANDARD 1.1.9 Communication**

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Low

The policies on adverse events and serious and sentinel events address open disclosure procedures. There is an interpreter policy which includes references and educational material. A resource listing interpreter services is available if required.

Contact with family members following an incident is expected to be recorded on the accident/incident form (documented on three of the 11 incident forms reviewed) and in resident files reviewed. In addition contact with the family is recorded on the resident's communication with family record.

The summary of the satisfaction survey completed in May 2012 reports that residents agree that they are fully informed.

Four caregivers interviewed (two hospital and two rest home), the clinical manager and the registered nurse interviewed confirm that family are informed of any resident accidents or incidents.

There are no residents currently requiring interpreting services. One resident uses a Pollyanna communication device and staff are familiar with this.

Four of four family members including three hospital and one rest home confirm that there is good communication with the service.

Residents interviewed (six hospital and three rest home) confirm that they are communicated with well.

An improvement is required to documentation that family have been informed on the incident report.

**Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Contact with family members following an incident is expected to be recorded on the accident/incident form (documented on three of the 11 incident forms reviewed) and in resident files reviewed. In addition contact with the family is recorded on the resident's communication with family record.

**Finding Statement**

Eight of the 11 incident forms reviewed do not include documentation that family have been informed.

**Corrective Action Required:**

Ensure that the incident form includes documentation of family being informed.

**Timeframe:**

3 months

**Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The compliments and complaints policy describes the complaints management system. The policy addresses the requirements of Right 10 of the Code of Disability Services Consumers' Rights.

D13.3h: A complaints procedure is provided to residents within the information pack at entry. The complaints form is available at the entrance to the facility.

Documentation in the complaints file confirms that both verbal and written complaints are documented and investigated. Details of the investigation and letters to the complainant are documented for all complaints. Response timeframes are observed with the new manager and the regional manager overseeing the process.

D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term residential care in a rest home or hospital–what you need to know” is provided to residents on entry.

D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.

D16.4b: Four of four family members including three hospital and one rest home state that they are always informed when their family members' health status changes and they confirm that they know how to complain and state that they feel that their concerns/complaint would be addressed.

One family members interviewed states that they have made a complaint in the past and their complaint was taken seriously with evidence of resolution.

There is one complaint with the Health and Disability Commissioner currently under investigation. The service was advised of the complaint in March 2013 however the previous manager did not respond or notify the regional manager of the complaint. The regional manager responded as soon as she was made aware of the complaint in June 2013 and this included notifying the DHB of the complaint. The regional manager has continued to respond to the complaint in line with requests from the HDC.

The improvement identified at the previous audit around complaints has been addressed.

**Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

**STANDARD 1.2.1 Governance**

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The Radius Peppertree business plan is linked to the Radius Care Group strategies (clinical leadership, taking ownership of the business and services provided, effective financial leadership and management, marketing and innovation and new ventures and the Radius Care Group business plan targets 2012/13).

The executive management team based in head office are very involved in the service and have provided input into the resident/family meetings etc.

The mission statement is included in information given to new residents. The purpose is 'to create value for everyone involved with the business on a long term and sustainable basis' with the vision 'being accountable for guiding and continuously improving the quality of our service to be leaders'. An organisational structural chart is in place.

The manager began employment in the role in July 2013 having been the facility manager in a previous rest home/hospital She is supported in the management role by the regional manager who has been providing oversight for the service in the interim since the previous manager resigned two and a half months ago.

The residents and family members interviewed state that there has been continuity of care because of the regional manager continuing to be on site. 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 and rest home has part of her previous role.

**Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Evaluation methods used: D 🗷 SI 🗷 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

The quality manual describes the Radius quality philosophy and implementation procedures for the continuous quality improvement programme. Oversight is provided at monthly staff meetings (minutes sighted for 2013), through the monthly quality/health and safety meeting and the two monthly restraint meeting. A new meeting minute format is being used and this is ensuring that all aspects of quality and risk management are discussed.

Facility based data is collected monthly and entered into the Radius electronic data system by the manager and clinical manager. Incidents are recorded as a set of quality indicators which are used by each Radius aged care facility to monitor trends and to benchmark against other Radius facilities (sighted for Radius Peppertree for 2013).

Quality indicators include infections, wounds, pain assessment, falls, medication events, weight, restraint, clinical care, resident participation and work effectiveness, the use of psychotropic medications and the occurrence of serious/sentinel events. The clinical manager reports weekly to the regional manager on clinical effectiveness, audits completed and manual updates received and confirms that quality indicator data has been entered.

The Radius national operations management team, attended by regional managers and the general manager operations, include on the meeting agenda complaints, documents for review and upcoming audits. An action plan accompanies each identified item. Minutes confirm that monitoring of internal quality activity at Radius Peppertree occurs at the quality and health and safety meetings.

Risks are identified in the Radius quality and risk management plan and in the site specific risk management plan. Risks identified include those related to clinical care, human resources, health and safety, the environment and financial management. These are reviewed annually in line with the end of the financial year at a facility and national level - outcomes at the facility level inform the Radius business and risk management plan for the coming year. A current hazard register is in place.

An internal audit schedule is implemented and there is a template for recording corrective actions.

Incidents and accidents are accurately recorded and reported and the resulting information is evidenced as having been discussed at the meetings.

The improvements identified at the previous audit around discussion of quality data at meetings, implementation of the audit schedule, monthly reports of incidents and accidents as a true record have been addressed.

An improvement continues to be required around corrective action plans.

**Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.**

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

The quality manual describes the Radius quality philosophy and implementation procedures for the continuous quality improvement programme. Oversight is provided at monthly staff meetings (minutes sighted for 2013), through the monthly quality/health and safety meeting and the two monthly restraint meeting. A new meeting minute format is being used and this is ensuring that all aspects of quality and risk management are discussed.

An internal audit schedule is implemented and there is a template for recording corrective actions.

**Finding Statement**

Corrective actions are identified where there are findings following internal audit however there continues to be a lack of documentation to indicate that the findings are signed off as being resolved.

**Corrective Action Required:**

Corrective action plans are developed as a result of identified shortfalls. A process to demonstrate on-going monitoring and close out is to be implemented..

**Timeframe:**

3 months

**Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:**

(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;

(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

D19.3b; there is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

Radius Peppertree understands the requirements of situations requiring notification, for example to HealthCERT / Director General of Health in accordance with reporting requirements as documented on the certification notice and around reporting requirements to the DHB as identified in the service contract. The regional manager states that the DHB has been notified of one complaint.

All adverse events are recorded on the accident/incident form.

Incidents recorded on the monthly data sheet are able to be tracked to resident files.

The review of 11 resident incidents reported in 2013 provides evidences that the name of the resident, NHI number, the date of the incident, the person reporting the incident and the nature of the event are identified. The investigation and suggested actions are not closed out on three of the 11 incident forms reviewed.

The improvement identified at the previous audit around documentation of incidents on the incident forms and including these in the monthly collation of data has been addressed.

An improvement is required to review of incident forms by the manager/s.

**Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

The review of 11 resident incidents reported in 2013 provides evidences that the name of the resident, NHI number, the date of the incident, the person reporting the incident and the nature of the event are identified.

The service has an incident and accident data sheet that includes name, place, date and time, type, injury/site, cause, resident/staff/visitor, doctor notified, hazards identified and action taken. Data is aggregated monthly (summary's for falls, medication, skin tears sighted). Once the incident is recorded on the monthly data sheet the incident form is then placed in the resident file - incidents recorded on the monthly data sheet are able to be tracked to resident files.

The clinical manager and the registered nurse interviewed are familiar with the incidents and follow up as documented in the care plans reviewed.

**Finding Statement**

The incident forms are not reviewed by the manager/s on three of the 11 incident forms reviewed.

**Corrective Action Required:**

Ensure that all incident forms are reviewed by the clinical manager and/or manager.

**Timeframe:**

3 months

**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.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Low

Policies related to HR are documented including credentialing, orientation, performance and development reviews, performance management and recruitment, selection and appointment. These are implemented.

The clinical manager, registered nurses and other health professionals linked to the service have current practising certificates.

Job descriptions describe the key accountabilities, reporting line and performance measures for each role within the organisation.

A comprehensive orientation process is completed for each employee. Subjects addressed during orientation are highlighted on the in-service training planner. A workbook and checklist is used to record the orientation for each role. Each new employee is given a copy of the employee handbook that documents key procedural responsibilities. New staff including the caregiver interviewed who has been with the service for a short time has an orientation on file.

An in-service training planner notes the training required and attendance records are documented. Attendance records show that staff participate.

Review of five of five staff files (clinical manager, one registered nurse, three caregivers) confirms that each one of the five employees has an annual performance appraisal. The service is aware of the gap and has set up a schedule to address.

Interviews with four caregivers confirms that all completed an orientation process, a buddy system operates, in-service training occurs regularly and opportunities for external training are available.

Family and residents state that staff are knowledgeable and the caregivers, registered nurse and the clinical manager are able to describe care and support required as per care plans.

The service meets the requirements of the ARC contract.

Improvements required at the previous audit around orientation and training have been addressed.

An improvement is required to performance appraisals.

**Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Review of five of five staff files (clinical manager, one registered nurse, three caregivers) confirms that each one of the five employees has an annual performance appraisal. The service is aware of the gap and has set up a schedule to address.

**Finding Statement**

Performance appraisals are not completed annually for all staff.

**Corrective Action Required:**

Complete performance appraisals as per schedule.

**Timeframe:**

6 months

**STANDARD 1.2.8 Service Provider Availability**

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Low

The rosters reviewed for 2013 evidence that the following staffing occurs: a registered nurse on all shifts. The service is split into two areas - a hospital wing and a rest home hospital wing. In the hospital wing there are four caregivers morning (three full shift and one 7am-1pm) and afternoon and two overnight. In the hospital/rest home wing there are four in the morning (one 7am-1pm), three in the afternoon and one overnight. There is an extra registered nurse in the weekends from 7am-1pm.

A list of registered nurses and the clinical manager on call for all shifts is available to staff.

Interview with four of four caregivers indicates that there are sufficient staff in the morning and night shift although they state that they struggle to answer call bells at times on the afternoon shift.

Two of four family members and four of the nine residents interviewed state that there are times when call bells take a long time to get answered. Other residents and family members note that staff are 'very busy'.

There are a total of 54 staff including seven registered nurses, 29 caregivers, one clinical manager, one manager, seven kitchen staff, two administrator/receptionist, four cleaners and one laundry staff.

An improvement is required to staffing.

The service meets the requirements of the ARC contract.

**Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

The policies on acuity and clinical staffing ratios and human resources planning describe the baseline staffing levels for rest home level care and hospital level care.

**Finding Statement**

Nine of nine residents (six hospital and three rest home) and four of four family members including three hospital and one rest home state that there are adequate numbers of staff on duty in the morning however four residents and three family state that bells are not always answered promptly. Residents state that they sometimes wait for half to one hour for someone to come.

**Corrective Action Required:**

Review staffing response to call bells to ensure that residents are supported in a timely manner.

**Timeframe:**

3 months

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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.

**STANDARD 1.3.3 Service Provision Requirements**

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Low

There is a policy and process that describe resident’s admission and assessment procedures.

D16.2, 3, 4: The five files reviewed (three hospital and two rest home), identified that in four of five files an assessment was completed within 24 hours and all five files identify that the long term care plan was completed within three weeks. In the fourth file, the resident has been transferred to another rest home but decided to come back to Radius Peppertree. The original initial assessment was not redone however a brief assessment and care plan has been completed.

There is documented evidence that the care plans were reviewed by a registered nurse and amended when current health changes.

All five of five care plans evidenced evaluations completed at least six monthly.

D16.5e: Five of five resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly.

A range of assessment tools are completed in resident files on admission and completed at least six monthly in four of the five files reviewed. These include a) falls risk assessment b) pressure area risk assessment, c) continence assessment d) cultural assessment, e) skin assessment, f) and nutritional assessment and g) pain assessment.

Activity assessments and the activities sections care plans have been completed by the activities coordinator.

Care plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs. The care summary is reviewed as part of the regular resident review process (at least six monthly or sooner if needs change). Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery.

General consent forms and resuscitation forms are completed in all files reviewed with evidence of annual review.

Tracer Methodology: Rest Home resident

*XXXXXX This information has been deleted as it is specific to the health care of a resident.*

Tracer Methodology: Hospital resident

*XXXXXX This information has been deleted as it is specific to the health care of a resident.*

**Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

D16.2, 3, 4: The five files reviewed (three hospital and two rest home), identified that in four of five files an assessment was completed within 24 hours and all five files identify that the long term care plan was completed within three weeks. In the fourth file, the resident has been transferred to another rest home but decided to come back to Radius Peppertree. The original initial assessment was not redone however a brief assessment and care plan has been completed.

There is documented evidence that the care plans were reviewed by a registered nurse and amended when current health changes.

All five of five care plans evidenced evaluations completed at least six monthly.

**Finding Statement**

i) The frequency of dressing changes is documented for a skin tear (every third day) however the resident has had one dressing change on the third day and the second six days later. ii) Assessments are not reviewed six monthly as per policy. This improvement is identified at the previous audit (1.3.4.1) . iii) The MDT meeting is expected to be held annually however this was last held in May 2012 (note that the clinical manager is already addressing gaps in frequency of MDT meetings).

**Corrective Action Required:**

i) Ensure dressings are changed as per documentation. ii) Ensure that assessments are reviewed six monthly as per policy. The previous improvement required continues (1.3.4.1). iii) Ensure that MDT meeting are held annually.

**Timeframe:**

6 months

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.4 Assessment**

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

A comprehensive initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. Personal needs outcomes and goals of residents are identified. A range of assessment tools are completed in resident files and reviewed at least six monthly including falls, pressure areas and continence. Nutrition and pain are assessed on admission and as needed and weights and BP's are monitored on a weekly to monthly basis dependant on needs. Assessments are conducted in an appropriate and private manner. All residents interviewed are satisfied with the support provided.

Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Nine residents interviewed (three from the rest home and six from the hospital) and four family members state that they are informed and involved in the assessment process.

Five resident files reviewed show that the initial assessments are conducted within specified timeframes on entry to the service

The improvement required at the previous audit had not been addressed (refer 1.3.3.3 - was improvement for 1.3.4.1).

The improvement around ensuring that assessments and interventions outcomes are communicated to all concerned is addressed (1.3.3.4).

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Five of five files reviewed show that care plans are written by a registered nurse with the clinical manager providing oversight.

All files have a documented care plan with relevant interventions documented.

Four of four caregivers and the registered nurse and clinical manager interviewed are clear that the registered nurse responsibility is to write the care plans with input from the caregivers.

All of the five resident files include interventions to the detail that supported the resident or met the needs of the residents.

The previous improvement required around ensuring that care plans describe the required support and interventions and is completed by the RN/ clinical manager is addressed.

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.5.3 Service delivery plans demonstrate service integration.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

D18.3 and 4 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 and this could be described.

Continence management in-services and wound management in-service has been provided.

Wound assessment and wound management plans are in place for ‘number’ residents.

The registered nurse and clinical manager interviewed describe the referral process and related form should they require assistance from a wound specialist or continence nurse.

Interventions are individualised and well documented in the five care plans reviewed. The care plans also showed evidence that these had been updated as changes occur. Two of the residents reviewed had been transferred back from the public hospital in the last week following acute admissions and both care plans reflect directions documented in the discharge summaries.

Nine of nine residents interviewed (six hospital and three rest home) state that the interventions provided by staff are appropriate to their needs and are provided in a respectful manner.

**Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The diversional therapist employed by the service has worked at Radius Peppertree for 20 years. She works six and a half hours a day for five days a week. She predominantly spends Monday and Friday with hospital residents noting that hospital residents join with rest home residents for activities. All recreation/activities assessments are up to date (completed when the resident enters the service and updated as changes occur).

On the day of audit, residents were observed being actively involved with a variety of activities in the lounges.

Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Activities include tai chi weekly, games, walking groups, concerts, entertainers and outings. There are also visits from community groups with music being a focus for entertainers.

All nine residents interviewed state that activities are appropriate and varied. The two residents identified as under a YPD contract state that the activities are appropriate.

The resident admitted under the DHB health recovery contract states that she has already been asked if she would like to engage in activities.

D16.5d: Five of five resident files reviewed identified that the individual activity needs are reviewed at care plan review.

**Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated.

D16.3c: All initial care plans are evaluated by the RN within three weeks of admission.

All initial care plans are developed by a registered nurse within three weeks of admission and evaluated at least six monthly or if there is a change in health status. The GP documents to indicate that there is a three monthly review.

There is documented evidence that evaluations are up to date in all five care plans reviewed. Overall changes in health status are documented and followed up. Care plan reviews are signed as completed by a registered nurse.

A review of care plans indicates that there the care plan is updated as changes occur.

There are no residents identified on the day of the audit requiring a change in level of care (noting that the GP is currently processing one resident for reassessment).

Improvements identified in the previous audit around care plan evaluations and review of risk have been met.

**Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Evaluation methods used: D 🞏 SI 🞏 STI 🞏 MI 🞏 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There are policies and processes that describe medication management that align with accepted guidelines. Medications are checked against the doctor's medication profile on arrival from the pharmacy by a registered nurse. 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.

Resident medication charts are identified with demographic details and photographs. The fridge that medications are kept in has a weekly temperature check as does the fridge used for lab specimens.

The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication record. All 10 medication charts reviewed had allergies (or nil known), documented. The service documents adverse reactions and errors on incident/accident forms.

There is a locked cupboard in each medication room (treatment room) that is used for controlled drugs and the room is locked. There are drug trolleys that are kept in the treatment rooms which are locked when not in use.

A medication round was observed; all practice is appropriate.

A medication competency has been completed annually by all staff who administer medication.

There is a policy and process that describes self-administered medicines. Two resident files were reviewed who self-administer medication. Both had a checklist to determine competency and the competency was signed off by the GP.

D16.5.e.i.2: Nine of 10 medication charts reviewed identified that the GP had reviewed the medication and resident three monthly and the medication chart was signed. One had been reviewed at one point in four months.

Multiple copies of medication charts have been removed and the original chart is updated by the GP.

All medication charts include a resident's photo on them.

Controlled drugs that are no longer required are returned to the pharmacy.

There are no signing gaps identified in the 10 files reviewed and the clinical manager states that these would be reported as a mediation error if identified.

Improvements required to self-administration, medication charts and controlled drugs have been addressed.

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The service has a large workable kitchen. The kitchen and the equipment are well maintained. The service provides meal services at Radius Peppertree over seven days a week. There is a rotating four weekly menu in place that was designed by a dietician. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed.

A registered nurse completes each residents nutritional profile on admission with the aid of the resident and family. Special diets are catered for and documented in the kitchen including the new diet for a resident recently discharged from the public hospital.

Food safety information and a kitchen manual are available in the kitchen. Food served on the day of audit was hot and well presented.

The service encourages residents to express their likes and dislikes. The residents interviewed were complementary about meals provided and they all stated that they are asked by staff about their food preferences. Equipment is available on an as needed basis. Residents requiring extra support to eat and drink are assisted, this was observed during lunch.

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. Fridge/freezer temperatures are checked daily. Food in the fridge and chiller were covered and dated. The kitchen is clean and all food is stored off the floor. Chemicals are locked away.

Food audits are carried out as per the yearly audit schedule.

D19.2: Kitchen staff have been trained in safe food handling.

**Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

**STANDARD 1.4.2 Facility Specifications**

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The building holds a current warrant of fitness which expires on 5 April 2014.

Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted by an external fire safety contractor. When an issue requiring maintenance is noticed the manager contacts the maintenance person on the same day and in most cases the issue can be repaired or resolved on the same day. External contractors are engaged to complete work as required.

Hot water temperatures have all been taken and are within range at (or just below) 45 degrees.

The facility's amenities, fixtures, equipment and furniture are appropriate for rest home, hospital and DHB health recovery residents. It is also suitable for residents under an YPD contract.

There is sufficient space to allow residents to move around the facility freely. All hospital level rooms have sufficient space for equipment and for staff to work. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted.

The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Resident’s bedrooms throughout the facility have resident's own personal belongings displayed. External areas and garden areas surrounding the facility are well maintained. Level paths to the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained. On interview nine residents and four family members were happy with the access around the facility.

D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors and lifting aids.

**Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS**

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Restraint minimisation and safe practice policy and procedure includes; a) definitions, b) use of restraint is a last resort only, c) methods of restraint permitted within Radius, d) use of enablers, e) enablers permitted with radius, f) client rights, g) assessment, discussion & restraint alternatives, h) restraint alternatives are not effective, i) restraint care, j) monitoring and removal, k) restraint episode evaluation, l) risks associated with restraint, m) restraint coordinator, n) staff training, o) restraint meetings, and p) maintenance.

Related forms include: restraint assessment, discussion and alternatives form; restraint discussion and consent form; restraint monitoring form; enabler assessment and consent form; restraint register; enabler register; care plan for client requiring restraint; restraint episode evaluation form.

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 four residents with enablers (bed rails) in the hospital and six residents using restraint (five in the hospital and one in the rest home).

Bedsides identified as enablers are in use while the resident is in bed and two hourly monitoring is conducted while the bed rails are in position. These were requested by the residents.

The restraint minimisation and safe practice policy outlines the process that staff should follow before enablers are implemented and includes identifying at risk behaviours, assessment procedures, alternatives and de-escalation techniques, discussion with multidisciplinary team, client and family/whanau, development of an enabler care plan, monitoring, reduction, removal and evaluation of enablers.

The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of the file of the resident with an enabler.

**Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Restraint minimization and safe practice staff training and education were provided for staff in June 2013 with restraint competencies completed by all staff in June 2013. All staff have also have restraint skills sighted and signed off by the restraint coordinator (clinical manager) in June 2013.

Four of four caregivers interviewed are able to describe the use of restraint including assessment, planning and monitoring requirements.

A resident file with documentation around restraint was reviewed and this includes a signed consent form, assessment, plan and monitoring forms completed as per the documentation.

The previous improvement identified around training for staff around restraint has been addressed.

**Criterion 2.2.3.2 Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:**

(a) Only as a last resort to maintain the safety of consumers, service providers or others;

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

(d) When the environment is appropriate and safe for successful initiation;

(e) When adequate resources are assembled to ensure safe initiation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:**

(a) Details of the reasons for initiating the restraint, including the desired outcome;

(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;

(c) Details of any advocacy/support offered, provided or facilitated;

(d) The outcome of the restraint;

(e) Any injury to any person as a result of the use of restraint;

(f) Observations and monitoring of the consumer during the restraint;

(g) Comments resulting from the evaluation of the restraint.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.3.5 A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Low

The surveillance programme is outlined in policy and is determined by the infection control team (all staff). A monthly infection summary report is completed. The surveillance programme includes monthly analysis of infections, monthly surveillance record form, project/product consultation form and quality indicator data report form completed. Infections are documented on the infection monthly surveillance register and a monthly analysis of infections record is completed. Infections treated with antibiotics are documented however infections that are not treated with antibiotics are not included.

Infection control data is collated monthly and reported to the monthly quality/health and safety meeting with numbers of infections documented.

The surveillance of infection data assists in evaluating compliance with infection control practices.

The infection control programme is linked with the Radius quality management programme through the operational management team meetings monthly with benchmarking completed against indicators. The graphs are now displayed in the staffroom for staff to view.

The infection control coordinator (registered nurse) is learning the role and the new manager is aware of the need to provide the registered nurse with training around infection control.

One of the GP's specifically asked is aware of the infection control programme and states that registered nurses and the clinical manager provide care for any resident with infections as per policy.

Improvements are required to training for the infection control coordinator, documentation of surveillance data and discussion of data through quality and health and safety meetings.

**Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

The surveillance programme is outlined in policy and is determined by the infection control team (all staff). A monthly infection summary report is completed. The surveillance programme includes monthly analysis of infections, monthly surveillance record form, project/product consultation form and quality indicator data report form completed.

Infections are documented on the infection monthly surveillance register and a monthly analysis of infections record is completed.

Infections treated with antibiotics are documented however infections that are not treated with antibiotics are not included.

The infection control coordinator (registered nurse) states that she has not had training around the role however she is enthusiastic and has retrospectively completed the infection control data analysis forms appropriately.

The clinical manager provides oversight of the infection control programme.

**Finding Statement**

i) There is no evidence of discussion around the infection control data collected including discussion after the norovirus outbreak in January 2013. ii) Infections not treated with antibiotics are not included in the surveillance data. iii) The infection control coordinator (registered nurse) states that she has not had training around the role.

**Corrective Action Required:**

i) Evidence discussion around infection control data with documentation that indicates that improvements are made as required. ii) Include infections not treated with antibiotics in the surveillance data. iii) Ensure that the infection control coordinator understands the role and has appropriate education for the role.

**Timeframe:**

6 months