

# Radius Residential Care Limited - Radius Rimu Park

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## 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: 10 October 2016      End date: 10 October 2016

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 40

# Executive summary of the audit

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## 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 provides rest home, hospital and psychogeriatric level care for up to 53 residents and on the day of the audit, there were 40 residents. The facility manager is a registered nurse. The residents and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed five of thirteen shortfalls from the previous surveillance audit around the regular review of facility goals, the evaluation and sign-off of corrective action plans, dating eye drops, essential notification requirements and reporting incidents in the residents' progress notes and staffing.

Further improvements continue to be required in relation to analysing and reporting quality results to staff, the pre-employment process, the orientation programme, the in-service and education programme, InterRAI assessments, interventions and wound evaluations, activity plans, and medication management.

This audit has identified no additional shortfalls.

## 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 manager/registered nurse are responsible for the day-to-day operations of the facility. A quality and risk management programme is in place. Corrective actions are evaluated and signed off when completed. Adverse, unplanned and untoward events are responded to in an appropriate and timely manner. An orientation programme is in place for new staff. Staffing rosters were sighted.

## Continuum of service delivery

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

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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A current building warrant of fitness is posted in a visible location. The psychogeriatric unit has an accessible and safe outdoor 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 three residents using bedrails as enablers and five residents using restraint. Staff receive education around restraint minimisation, which begins during their orientation and continues annually.

## 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 continues to implement 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)
<b>Standards</b>	0	10	0	4	2	0	0
<b>Criteria</b>	0	33	0	6	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 eight residents (four hospital, four rest home) and family confirmed their understanding of the complaints process. Three managers (facility manager, clinical manager, interim clinical manager) and eight staff (two healthcare assistants, three registered nurses, two activities coordinators, and one cook) could explain the process around reporting complaints.</p> <p>The complaints register includes verbal and written complaints. Evidence was sighted to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, meeting timelines, corrective actions when required, and resolution.</p> <p>One complaint lodged with the Health and Disability Commissioner (HDC) has resulted in the implementation of defined and documented corrective actions. This complaint remains open with HDC. Northland DHB has received four complaints in 2016. These complaints have been investigated and are recorded on the complaints register as closed.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided</p>



<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>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. Four relatives interviewed (two hospital, two psychogeriatric) stated they were kept well informed. Ten incident/accident forms reviewed identified that the next of kin were contacted or if not, justification as to why not, was recorded.</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>FA</p>	<p>Radius Rimu Park provides rest home, hospital and psychogeriatric levels of care for up to 53 residents. On the day of the audit, there were 40 residents with 11 at rest home level, 16 at hospital level and 13 at psychogeriatric level of care. All 31 residents' rooms in the rest home and hospital are dual-purpose. There was one resident on respite (hospital level) and one resident on ACC (hospital - medical level). All other residents were either on the aged related contract or age related hospital specialist services contract.</p> <p>The facility manager is a registered nurse (RN) and had been at the facility for four weeks. Before this role, the facility manager was the general manager for hospital services in a rural community, which included aged care and palliative care. 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 an RN who had been employed for two months. Before this role, she was a district nurse for 21 years.</p> <p>The facility's business plan for 2016 is linked to the Radius Care Group strategies and business plan targets. The mission statement is included in information given to new residents. Goals are documented for 2016 with evidence of the goals being regularly reviewed. This is an improvement from the previous audit.</p> <p>The facility manager has attended a 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, documented, and maintained quality and risk</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 the policy and that it is understood. 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. An annual</p>

<p>management system that reflects continuous quality improvement principles.</p>		<p>internal audit schedule confirmed audits are being completed as per the schedule. Quality data is not consistently analysed and staff meeting minutes do not reflect adequate detail about quality and risk management results. This previously identified area for improvement remains. Corrective actions are developed, implemented and evaluated where opportunities for improvements are identified. This is an improvement from the previous audit.</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) and is meeting current health and safety requirements.</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>FA</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 linked to the quality and risk management programme (link to finding 1.2.3.6).</p> <p>Ten incident/accidents were reviewed. 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, they are processed as hazards using a hazard identification form.</p> <p>The facility manager is aware of statutory report obligations and provided examples of when this has been required. This is an improvement from the previous audit.</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 registered nurses and other health professionals were current. Five staff files were selected (one clinical manager/RN, one RN, and three healthcare assistants). The sample size included employees who had been employed since the last audit. Not all files reviewed evidenced that reference checks had been completed. This area for improvement remains.</p> <p>Signed employment contracts and job descriptions were evident in the sample of staff files reviewed. Interviews with care staff described the orientation programme that includes a period of supervision. Not all files reviewed evidenced completed orientation documentation. This remains an area for improvement.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented and attendance is recorded. Attendance is less than 50% for mandatory training. Not all</p>

		<p>healthcare assistants working in the psychogeriatric unit for over one year have completed their dementia qualification. This area for improvement remains. Two of nine registered nurses, one who is the interim clinical manager, have completed their InterRAI training (link 1.3.3.3).</p> <p>A minimum of one care staff is available 24/7 with a current first aid/CPR certificate.</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>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The facility manager and clinical manager are both registered nurses. A minimum of two RNs are scheduled 24 hours a day, seven days a week. In addition to the RNs, there are a minimum of two healthcare assistants rostered on any shift. Two activities staff, which includes one activity therapist who has completed the dementia standards, are onsite Monday – Friday.</p> <p>Families and residents interviewed advised that they felt there was sufficient staffing in the rest home/hospital. Two of the two families (psychogeriatric) expressed concern in relation to staffing in the psychogeriatric unit. However, staff interviewed stated they were managing and that more hours are added when needed. The roster is able to be changed in response to resident acuity. Staff were observed to be actively supervising the lounge areas during the audit. Rosters reviewed met the ARHSS and ARC contract requirements.</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>	PA Low	<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 all of the ten sampled had photographs. Allergies were documented. Daily temperature checks have been conducted for the medication fridges.</p> <p>All medications are stored appropriately. Eye drops have been dated on opening.</p> <p>There is one resident who self-administers medication. An initial competency assessment has been completed, however, three monthly reviews of self-medication competency has not been completed.</p> <p>Nine of ten (one residents had been at the service less than three months) medication charts reviewed identified that the GP had seen the reviewed resident three monthly and the medication chart was signed. All medication charts document the indication for giving the 'as needed' medication.</p>

		Previous audit findings around signing for medication on administration and weekly medication checks have been rectified.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service continues to manage and provide a high standard of meal services. The kitchen and the equipment are well maintained. The service employs sufficient kitchen staff to provide meal services over seven days a week. There are rotating four weekly menus in place 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 are available in the kitchen. Food served on the day of audit was hot and well presented.</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>	PA Moderate	<p>All resident files reviewed had care plans in place. When a resident's condition changes, the RN initiates a GP/NP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Care plans lacked elements of documentation needed. This is a continued finding. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status.</p> <p>Contenance products are available and resident files include a three-day 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 by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies.</p> <p>Nine wounds were documented on the day of audit and included three skin tears and a leg ulcer in the psychogeriatric unit, three skin tears, one blister, one friction burn and one pressure injury in the hospital.</p> <p>Wound care plans were paper-based and included an assessment, wound management and evaluation forms, however; not all wounds had completed documentation. The previous finding remains unmet. Short-term care plans were in place and documented regular review. The grading of pressure injuries</p>

		<p>and timeframes for wound review are improvements since the previous audit.</p> <p>Monitoring charts were in use and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	PA Low	<p>There is an activities coordinator who provides activities in the rest home/hospital and an activities coordinator who provides activities in the psychogeriatric unit. The activities coordinator in the PG unit has completed the dementia standards. Both staff members are employed five days a week.</p> <p>In the psychogeriatric unit and rest home/hospital, activities are planned and documented monthly. However not all residents in the psychogeriatric unit have an individualised activity plan documented.</p> <p>Many activities in the hospital/rest home recur at regular times at resident's request. 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. Attendance at activities is recorded. This aspect of the previous finding has been addressed.</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><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The service continues to ensure that all long-term care plans are 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. 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 ongoing as sighted in resident files sampled. Updates to the care plans were documented in the files reviewed where the resident condition has changed.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that</p>	FA	<p>A current building warrant of fitness is posted in a visible location (expiry date 1 June 2017). There is an accessible outdoor area for the psychogeriatric residents. The psychogeriatric unit has an accessible internal courtyard for residents that comply with contractual requirements and health and disability sector standards. This (outdoor) area is safe and includes seating, a sheltered area, and pathways to walk.</p>

are fit for their purpose.		
<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>	FA	<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>	FA	<p>The use of restraint is regarded as a last intervention when all other interventions 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 three residents with enablers in the form of bedrails in the hospital. The residents requested these. The assessment process ensures enablers are voluntary and the least restrictive option. One resident file, where an enabler was being used, was reviewed and reflected evidence of the assessment and consent process.</p> <p>There were five residents (two psychogeriatric and three hospital) using restraints.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Adverse event data (e.g., falls, skin tears, staff accidents, pressure injuries, infections) data is collected, and collated. Data is not consistently analysed and staff are not provided with meaningful results.	Quality data is not consistently analysed and evaluated for adverse events. Staff meeting minutes do not reflect adequate detail being communicated to staff regarding the quality and risk data results identified from adverse events.	Ensure quality data relating to adverse events is regularly analysed and staff are kept informed regarding quality and risk management results.  60 days
Criterion 1.2.7.3	PA Low	Staff files contain evidence of the recruitment process, which includes a formal interview. Applicants undergo police vetting. One	There was a lack of evidence to support	Ensure reference

<p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>		<p>of five staff files selected indicated that reference checking had occurred.</p>	<p>reference checking for four of five employees hired since January 2016.</p>	<p>checks are completed as part of the recruitment process.</p> <p>60 days</p>
<p>Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>New staff undergo an orientation programme that covers both general and job specific duties. Evidence of completed orientation checklists were sighted in the RN and clinical manager files but were missing in all three healthcare assistants' files. Whilst it is acknowledged that they may have still been working on completing their orientation workbooks, a signed copy that they have read the staff handbook was also not available for sighting. The healthcare assistants interviewed reported that they all complete an induction programme, which includes a period of supervision, but sometimes forget to hand in their completed orientation papers.</p>	<p>Three healthcare assistants' staff files reviewed were missing evidence of completed orientation programme documentation.</p>	<p>Ensure staff files reflect evidence of staff completing an orientation programme, including but not limited to a signed copy that they have read and agree to guidelines set forth in the staff handbook.</p> <p>60 days</p>
<p>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.</p>	<p>PA Moderate</p>	<p>An education and training schedule is in place for staff that includes both mandatory and job specific education. Training at mandatory in-services is below 50%. The psychogeriatric unit is staffed with fourteen regular healthcare assistants. Eight have been employed for over one year. Three of eight healthcare assistants who have worked in the psychogeriatric unit for over one year have completed their dementia qualification. One registered nurse and one interim clinical manager are trained in the use of the InterRAI assessment tool. The regional manager reports that the service has had difficulty accessing training around InterRAI requirements (link 1.3.3.3).</p>	<p>i. Staff attendance at mandatory training for 2016 (e.g., abuse/neglect, accident/incident reporting, code of rights/complaints/advocacy, aging process, emergency procedures, health and safety) is less than 50%. ii. Five of eight healthcare</p>	<p>i. Ensure staff attend all mandatory training. ii. Ensure that all healthcare assistants who have been employed in the</p>



			<p>assistants have not completed the required dementia qualification.</p> <p>iii. Insufficient numbers of registered nurses have completed the InterRAI qualification.</p>	<p>psychogeriatric unit for over one year, hold a dementia qualification.</p> <p>iii. Ensure that there are sufficient numbers of registered nurses trained in InterRAI.</p> <p>60 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	<p>One self-medicating resident has an assessment and competency signed by the resident and the GP. This had not been reviewed three monthly.</p>	<p>One self-medication chart sampled did not have a three-monthly review of the competency completed.</p>	<p>Ensure that self-medicating competencies are reviewed within set timeframes.</p> <p>90 days</p>
<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>	PA Low	<p>The registered nurses interviewed were familiar with contractual timeframes around care plans. The regional manager reports that the service has had difficulty accessing training around InterRAI requirements and there is now only one registered nurse who is InterRAI trained (link to 1.2.7.5). All residents had a comprehensive suite of paper-based assessments completed but not InterRAI assessments.</p>	<p>InterRAI assessments were not in place for one hospital resident and one of three psychogeriatric resident files reviewed.</p>	<p>Ensure all residents have an InterRAI assessment completed in a timely manner.</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. The wound care forms are not fully completed and some forms have more than one wound. Wound care documentation and care plan interventions are repeat findings.</p>	<p>i) Care plan interventions are lacking and do not describe the care and support required to manage and monitor three residents with behaviour in the psychogeriatric unit including a lack of interventions that describe care for non-verbal communication, continence problems and not liking being alone.</p> <p>ii) Incomplete wound documentation included more than one wound on a form for two wounds (both psychogeriatric) and two wounds (one hospital and one psychogeriatric) documented the wound had been redressed, but there was no evaluation of the wound.</p>	<p>(i) Ensure all identified needs are addressed in care plans.</p> <p>(ii) Ensure each wound has a documented evaluation of wound healing process and each wound has its own wound management plan.</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 month are documented monthly. Attendance of residents at activities is documented and activities are planned on a monthly basis, this is an improvement on the previous audit. Regular reviews of activity plans occur as documented in two of three files with an individual plan. (One rest home was a short stay respite). One of three resident's files reviewed in the</p>	<p>One of three psychogeriatric resident files reviewed did not have an individualised activity plan.</p>	<p>Ensure that all residents have an individualised activity plan documented.</p> <p>60 days</p>

		psychogeriatric unit did not have an individualised activity plan.		
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.