

# Radius Residential Care Limited - Radius Arran Court Home & Hospital

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## Introduction

This report records the results of a Certification 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 Arran Court Rest Home & Hospital

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

**Dates of audit:** Start date: 5 December 2016      End date: 6 December 2016

**Proposed changes to current services (if any):** The service has been verified as suitable to provide residential disability level care - physical.

**Total beds occupied across all premises included in the audit on the first day of the audit: 94**

# 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

Arran Court is owned and operated by Radius Residential Care Limited and is certified to provide care for up to 102 residents requiring rest home and hospital (medical and geriatric). On the day of the audit there were 94 residents. This audit also included assessing the service as suitable to provide residential disability level of care - physical.

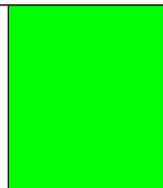
The service is managed by a registered nurse with experience in aged care management. She is supported by a Radius regional manager and a clinical manager (currently on maternity leave). Residents and relatives spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

This audit has identified areas for improvement around progress notes, timeliness of documentation, care planning, care interventions (assessed as high risk) and medication administration.

## 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.



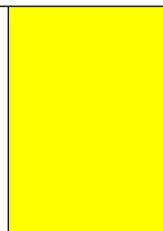
Standards applicable to this service fully attained.

Policies and procedures adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

## 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 low risk.

A facility manager and interim clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded in practice. Results are shared with staff. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments. Registered nursing cover is provided 24 hours a day, 7 days a week.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Entry to the service is managed primarily by the registered nurses. There is comprehensive service information available. Initial assessments are completed by a registered nurse. Residents and family interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

Medication is stored appropriately in line with legislation and guidelines. Staff have completed education around medication management and all staff who administer medications have completed a competency assessment. Medications are stored and prescribed in line with appropriate guidelines and regulations. General practitioners review residents at least three-monthly or more frequently if needed.

Meals are prepared on-site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All rooms are single occupancy and several have their own ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

## 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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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures for the safe assessment and review of restraint and enabler use. A register is maintained. During the audit five residents were using a restraint and nine residents were using enablers.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

## 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	45	0	1	3	1	0
<b>Criteria</b>	0	96	0	1	3	1	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Radius Arran Court Rest Home and Hospital policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with sixteen care staff (eight caregivers across the am and pm shifts, one physiotherapy assistant, four registered nurses (RNs) and three activities staff) confirmed their understanding of the Code. Fifteen residents (seven hospital level including three young persons with a disability and eight rest home level) and seven relatives (four hospital relatives including two with a family member who is a young person with a disability; and three rest home relatives) interviewed confirmed that staff respect privacy and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their EPOA. Advanced directives are signed for separately. In 10 files</p>

<p>are provided with the information they need to make informed choices and give informed consent.</p>		<p>reviewed there was evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>Ten of ten resident files sampled (three from the rest home, four from the hospital and three for residential disability) had a signed admission agreement and consents.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on residents' family/whānau and chosen social networks.</p> <p>The Nationwide Health and Disability Advocacy service is an invited speaker at resident/family meetings and staff training on the Code and the role of advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The service is responsive to young people with disabilities accessing the community, resources, facilities and mainstream supports such as education, public transport and primary health services in the community.</p> <p>The activities programme includes opportunities to attend events outside of the facility. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission.</p> <p>Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register that includes complaints received, dates and actions taken. The facility manager signs off each complaint when</p>

		<p>it is closed. There is evidence of lodged complaints being discussed in the staff meetings.</p> <p>Twenty-two complaints have been received in 2016. One complaint was lodged with HDC on 11 March 2016. Corrective actions have been implemented and HDC has closed the complaint with no further action required. Complaints are being managed in a timely manner, meeting requirements determined by HDC.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Young people with disabilities are able to maintain their personal, gender, cultural, religious and spiritual identify, evidenced in all three files reviewed of residents who were under the young persons with disabilities (YPD) contract.</p> <p>Care staff interviewed could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with caregivers described how choice is incorporated into resident cares.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p>	FA	<p>The Māori health plan policy for the organisation references local Māori healthcare providers regionally within New Zealand and provides</p>

<p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Māori cultural needs are addressed in the care plan.</p> <p>During the audit, there were two Māori residents living at the facility. The one resident interviewed reported that his cultural needs were being met.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Nine of ten resident files reviewed evidenced that individual beliefs or values are discussed and incorporated into the care plan (link 1.3.5.2). Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Policies and procedures are aligned with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.</p> <p>An annual in-service training programme is implemented as per the training plan with training for registered nurses from the DHB. Radius have provided a Radius roving clinical manager to support the clinical manager and interim clinical manager in their absence. Outcomes for the service are monitored with benchmarking across all Radius facilities. Feedback is provided to staff via the various meetings and through graphs and notices on the noticeboard in the staff room.</p> <p>There is a minimum of two RNs on the night shift with additional RNs on the am and pm shifts. A physiotherapist is available six hours a week</p>

		and is supported by a physiotherapy assistant. RNs and caregivers were described by residents and family as being caring.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 20 adverse events reviewed met this requirement when notification was appropriate. Family members interviewed confirmed they are notified following a change of health status of their family member.</p> <p>Monthly family/resident meetings provide a venue where issues can be addressed.</p> <p>There is an interpreter policy in place and contact details of interpreters were available.</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>	FA	<p>Radius Arran Court Rest Home and Hospital has a total of 102 beds and 94 beds were occupied during this certification audit. There are no dual-purpose beds. Thirty-six residents were rest home level including one resident on a long term chronic conditions contract (LTCC). Fifty-one residents were hospital level including one resident on ACC, one resident on a LTCC contract and one resident on respite. Seven residents were on the young persons with disability contract (three rest home level and four hospital level). This audit assessed the service as suitable to provide resident disability (physical) level of care.</p> <p>The Radius strategic plan describes the vision, values and objectives of Radius aged care facilities. The service organisation philosophy and strategic plan reflect a person/family centred approach. An annual business plan specific to Arran Court describes specific and measurable goals that are reviewed each month. The business plan is updated annually.</p> <p>The facility manager is a registered nurse who has worked in aged care for the past 13 years. She holds a bachelor's degree with a post graduate diploma in education. She has been in the role since May 2014 and is supported by a regional manager and a clinical manager (currently on maternity leave).</p> <p>The facility manager has maintained at least eight hours of professional</p>

		development activities related to managing an aged care facility.
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager/RN covers during the temporary absence of the facility manager. For extended absences, Radius has interim (roving) facility managers who cover facility manager absences. The regional manager is available on consultative basis.</p> <p>The clinical manager was on extended leave during this audit and the interim clinical manager was also on leave. A roving interim clinical manager was on-site for one week before the audit and during the two-day audit. Plans are in place to appoint three team leaders/RNs, one for each unit until the interim clinical manager returns (end January 2017).</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the managers (regional manager, facility manager and interim (roving) clinical manager/RN) and staff (sixteen care staff and four other staff including one cleaner, one cook, one maintenance, one administrator) reflected staff involvement in quality and risk management processes. Young people with disabilities have input into quality improvements to the service with examples provided. Satisfaction with choices, decision making, access to technology, aids equipment and services contribute to quality data collected by the service.</p> <p>Resident and family meetings are held each month. Minutes are maintained. Annual resident and relative surveys were completed in July 2016. Results were collated and discussed with staff. Corrective actions have been implemented and signed off.</p> <p>The service has policies and procedures and associated implementation systems, adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level by the clinical managers group with input from facility staff every two years. Clinical guidelines are in place to assist care staff. Updates to policies included procedures around the implementation of interRAI and health and safety to the new Act.</p>

		<p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements to a standard that exceeds the requirements. Results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are implemented when opportunities for improvements are identified (e.g., internal audit results are lower than 95%). Corrective actions are evaluated and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. Five health and safety representatives (one maintenance, RN, cook, administration and caregiver) were interviewed about the health and safety programme. Health and safety representatives have completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Radius has achieved tertiary level ACC WSMP (expiry 31 July 2018).</p> <p>Falls prevention strategies are in place including sensor mats, perimeter mattresses and intentional rounding.</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>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. They are signed off by the facility manager or clinical manager when complete.</p> <p>A review of 20 accident/incident forms identified that forms are fully completed and include follow up by a registered nurse. Accident/incident forms are completed when a pressure injury is identified. Neurological observations are completed for any suspected</p>

		<p>injury to the head.</p> <p>The facility manager and regional manager were able to identify situations that would be reported to statutory authorities including (but not limited to): infectious diseases, serious accidents and unexpected death. There was evidence of one Section 31 report completed for a grade III pressure injury (link 1.3.6.1).</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>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Ten staff files reviewed (three RNs, four caregivers, one kitchen assistant, one gardener, one cook) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. All staff participate in continuing education relevant to physical disability and young people with physical disabilities. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction. These competencies are repeated annually. Performance appraisals were up to date in all six staff files reviewed of staff who had been employed for one year or longer.</p> <p>Registered nurses are supported to maintain their professional competency. Four registered nurses have completed their interRAI training and one is currently in training. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies.</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>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale.</p> <p>The rest home unit (22 rest home, 10 hospital), hospital unit A (22 hospital, 10 rest home) and hospital unit B (24 hospital, six rest home) are all staffed with an RN on the AM and PM shifts. Two RNs cover night shifts. RN's are supported by adequate numbers of caregivers.</p>

		Staff were observed attending to call bells in a timely manner. This was also confirmed on review of the electronic call bell response schedule. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family interviewed also reported there are sufficient staff numbers.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low	The residents' files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Progress notes in the residents' files were lacking service integration.  A locked room stores archived residents' files.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical manager and/or manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the clinical manager or manager. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication round sighted. Medication prescribed is not always signed as administered on the pharmacy generated signing chart. Registered nurses administer medicines. All staff that administer medication are competent and have received medication management training. The RN on duty reconciles the delivery and documents this. Medication charts are written correctly by medical practitioners and there was evidence of three-monthly reviews by the GP. No current residents self-administer medicines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a fully functional kitchen and all food is cooked on-site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to residents should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	<p>FA</p>	<p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools (paper based and interRAI,</p>

gathered and recorded in a timely manner.		excluding younger people where interRAI is not required) were completed and assessments were reviewed at least six-monthly or when there was a change to a resident's health condition in files sampled. Care plans developed did not consistently reflect these assessments (link 1.3.5.2).
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	One of the ten long-term care plans reviewed, described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. Residents and their family/whānau are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans written in a manner that is easy to follow.
<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 High	<p>Registered nurses (RNs) (including the clinical manager) and healthcare assistants provide care as they understand it to be required (link 1.3.5.2) and report interventions completed each shift. The documented care provided does not always meet the needs of residents. If external nursing or allied health advice is required the RNs are expected to initiate a referral (e.g., to the district nurse). This has not always occurred promptly. If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring and wound management plans were in place for fourteen residents (ten hospital, one YPD and three rest home) with twenty-two wounds (two chronic ulcers, six skin tears, one open sinus, one supra public catheter site, four lesions, one blister, one laceration and eight pressure injuries), which are being appropriately managed with the exception of the pressure injuries for one resident. The wound rate at the facility appears high as even the most minor wounds (e.g. a scratch) are actively managed with a wound assessment and plan. The RNs have access to specialist nursing wound care management advice through the DHB.</p> <p>Care plan interventions including intentional rounding, turning charts and food and fluid charts demonstrate interventions to meet resident's</p>

		needs, are not always documented as occurring.
<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>	FA	<p>Three part-time activities coordinators are employed to provide the activities programme for all residents. Three programmes (one in each main lounge) operate simultaneously and residents can choose which programme interests them. Each resident has an individual activities assessment on admission and from this information an individual activities plan is developed as part of the care plan by the registered nurses with input from the activities staff. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. All long-term resident files sampled have a recent activities plan within the care plan and this is evaluated at least six-monthly when the care plan is evaluated. Residents and families interviewed commented positively on the activity programme.</p> <p>The service has developed a relationship with a local school and students visit regularly and engage on a one-to-one basis with residents. This was spoken about positively by residents and family members interviewed.</p> <p>Residential disability residents are encouraged and supported to engage in 1:1 and individual activities in the community with many attending social clubs and similar. Some activities are provided on a one-to-one basis to meet the unique needs of these residents.</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>All initial care plans are evaluated by the registered nurses within three weeks of admission. In files sampled the long-term care plans were evaluated at least six-monthly or on occasions earlier if there was a change in health status (link 1.3.3.3 and 1.3.5.2). There is at least a three-monthly review by the GP. Changes in health status have not always been documented and followed up (link 1.3.6.1). Care plan reviews have been signed by an RN. Short-term care plans were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is identified as different from expected, there was documented evidence that the service has responded by initiating changes to the care plan (link 1.3.5.2).</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services (link 1.3.6.1). Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed. Examples of liaison with dietitians, physiotherapists and mental health staff was sighted in resident files sampled.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness. The building has a number of alcoves and lounge areas with a main lounge in each of the three wings. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Several bedrooms have their own ensuites and some have shared ensuites. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids including those required by hospital level care residents. Residents are encouraged to personalise their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The communal areas include the main lounge and dining area in each wing and several smaller lounges and separate dining areas. The communal areas are easily and safely accessible for residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is done off-site. Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. The services emergency plan considers the special needs of young people with disabilities in an emergency. There is a minimum of one first aid trained staff member on every shift and during outings. The facility has an approved fire evacuation plan. Fire drills take place every six months. Smoke alarms, sprinkler system and exit signs are in place. Emergency lighting is in place which is regularly tested. A civil defence kit is in place. Supplies of stored water and food are held on-site and are adequate for three days. Electronic call bells are evident in resident's rooms, lounge areas and toilets/bathrooms. The facility is kept locked from dusk to dawn.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Radius Arran Court has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPI's. The facility manager (registered nurse) is the designated infection control nurse with support from the quality management committee (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Radius infection control programme was last reviewed in July 2016.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The facility manager at Arran Court is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the quality management team and care staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are Radius infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical</p>

		records.
<p><b>Standard 3.5: Surveillance</b></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>Infection surveillance is an integral part of the infection control programme and is described in Radius's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Radius head office. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There have been no outbreaks since the previous audit (one event was initially reported as an outbreak to public health but was confirmed not to be an outbreak and no outbreak reference number was issued).</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are three designated restraint coordinators, one for each unit (rest home, hospital A and hospital B). Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>There were nine (hospital level) residents using enablers (seven bedrails and two lap belts) and four (hospital level) residents using bedrails as restraint during the audit.</p> <p>A resident file of a resident using an enabler (bedrails) was reviewed. The resident gave written consent for the use of bedrails. The enabler was linked to the resident's care plan and was regularly reviewed.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</p>
<p><b>Standard 2.2.1: Restraint approval and processes</b></p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinators (two</p>

<p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		<p>RNs and one EN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by a restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and/or family/whānau are evident. Two residents' files where restraint (bedrails) were in use were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinators are responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan, sighted in both residents' files reviewed. An internal restraint audit monitors staff compliance in following restraint procedures.</p> <p>Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify monitoring was evidenced on the monitoring forms for the residents' files reviewed.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly. Restraint use is also discussed in the monthly restraint meetings, confirmed in the meeting</p>

		minutes.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The Radius restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.9.10</p> <p>All records pertaining to individual consumer service delivery are integrated.</p>	PA Low	All records pertaining to an individual resident are held in each resident's file, but progress notes are sometimes written in two different sections of each resident's file creating confusion.	Physiotherapy progress notes are held in the residents' files but are separate to the care staff's progress notes. In seven of ten residents' files, care staff accidentally documented residents' progress in the physiotherapy progress notes.	<p>Ensure the care staff progress notes reflect documentation in the same section of the residents' files and in a chronological order.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>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</p>	PA Moderate	Registered nurses have been assessed as competent to administer medications and were observed in two areas to administer according to appropriate practice. Medications are administered from trolleys stored in a treatment room in each of the three wings. However, administration records did not always document that administration had occurred.	Six of twenty medication administration sheets sampled did not have signatures to demonstrate that all prescribed medications had been administered.	<p>Ensure that medications are administered as prescribed.</p> <p>60 days</p>

guidelines.				
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>The registered nurses interviewed were familiar with contractually required timeframes. These were met in all except two files, one around evaluations and one where the resident was initially admitted as respite and a long-term care plan was not developed in a timely manner.</p>	<p>(i) One rest home level resident did not have the care plan evaluated between April 2015 and April 2016.</p> <p>(ii) One hospital level resident with significant risks who was initially admitted for a short stay did not have a long-term care plan. The unstageable pressure injury was not referred to a wound nurse specialist until four months after admission.</p>	<p>(i) Ensure that all care plans are evaluated at least six-monthly.</p> <p>(ii) Ensure that all residents have a comprehensive care plan developed in a timely manner.</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The Radius care plan which is used at Arran Court is a template document with a comprehensive range of headings and space for other needs. One of the ten care plans reviewed had documented all of the identified needs for the resident in the care plan (also link 1.3.6.1).</p>	<p>Nine of ten resident files sampled did not have all identified needs addressed in the care plan. Issues were as follows:</p> <p>Resident 1: Residential disability level resident. The care plan reflects that the resident is fully immobile with an air mattress, two hourly turns and hoist but the resident is mobilising with a quad stick and is now a falls risk.</p> <p>Resident 2: Rest home resident. The care plan did not include: nutritional needs/weight loss management, the next of kin request to be contacted when the resident was agitated so they could attend to settle the resident, current continence needs, current mobility meds, the requirement for subcut fluids if fluid intake is low and pressure injury risk.</p> <p>Resident 3: Hospital level resident. The care plan did not include: soft diet, weight loss management, an</p>	<p>Ensure that care plans document interventions to meet all of each resident's current needs.</p> <p>30 days</p>

			<p>indwelling catheter, PRN subcut fluids, fluid balance monitoring or current depression.</p> <p>Resident 4: Hospital level resident. The following issues were not addressed in the care plan: two hourly turns, vascular dementia, splints, abdominal binder when sitting and autonomic dysreflexia. The care plan states sling hoist but the resident uses a standing hoist.</p> <p>Resident 5: Residential disability level resident. The following issues were not addressed in the care plan: epilepsy, COPD, cultural needs, pressure injury risk and diabetic retinopathy.</p> <p>Resident 6: Hospital (LTCC). The care plan documents use of a behaviour chart that is no longer required. It does not address: walking frame, seizures, management of intoxication, ESBL status and a fluid restriction.</p> <p>Resident 7: Rest home level. The care plan does not address weight loss.</p> <p>Resident 8: Residential disability level. The care plan does not address intermittent chest pain.</p> <p>Resident 9: Rest home level resident. The care plan does not address: fluid restriction to 1500mls, angina, sensor mat, falls, nutrition, walking frame or PRN subcut fluids if intake less than</p>	
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			750mls.	
<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>	PA High	<p>A sample of ten resident files, staff interviews, GP interview and roving clinical manager interview indicated that basic cares such as hygiene needs are being well met but more complex needs are not always identified and/or addressed. A root cause analysis and corrective action plan had been commenced by the facility manager and regional manager prior to the completion of the audit.</p>	<p>Seven of ten files sampled were missing evidence that all identified needs were addressed:</p> <p>Resident 1: Hospital level:</p> <p>A pressure injury which photographs demonstrate was unstageable was documented as stage I in September 2016 and a short-term care plan developed. There is no further intervention other than dressing records since this time, until the interim clinical manager arrived at the facility one week prior to the audit. It was then identified as unstageable and a wound nurse specialist and dietitian referral made.</p> <p>Another pressure injury identified in mid-October 2016 as stage I has since deteriorated to stage II but this was not documented on the wound assessment. The fluid balance record has been erratically completed and not completed for the last two days and there was no evidence of it being balanced or reviewed by a registered nurse.</p> <p>Resident 2: Hospital level resident: The resident is required to have a fluid restriction but fluid intake is not monitored.</p> <p>Resident 3: Rest home level: The nurse practitioner ordered two days of further neurological observation monitoring and this was not</p>	<p>Ensure that all residents care needs are identified and implemented and recorded in a timely manner.</p> <p>7 days</p>

			<p>completed.</p> <p>Resident 4: Hospital level resident. There was no documented evidence of a medical review since admission in May 2016.</p> <p>Resident 5: Rest home level. The fluid balance chart has not been totalled daily or evidenced as reviewed by a registered nurse.</p> <p>Resident 6: Young person with disability. The expressed goal during interview and stated by family and in resident file is not the same as care plan. The interRAI assessment says no possibility of improvement but the resident is actively undergoing rehabilitation with tangible improvements. The care plan and physiotherapy assessments require the resident be walked daily – this is not occurring on the three days the physio assistant is not on-site.</p> <p>Resident 7: Rest home level: The initial MNA determined the resident required dietitian referral but this has not occurred. The behaviour chart has not been maintained and fluid balance is not monitored despite the resident being charted subcut fluids if the intake is below 750mls.</p>	
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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.

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End of the report.