

Radius Residential Care Limited - Radius Arran Court Home & Hospital

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 Arran Court Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 17 January 2018 End date: 18 January 2018
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:	99



Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

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, hospital (medical and geriatric) and residential disability level of care (physical). On the day of the audit there were 99 residents.

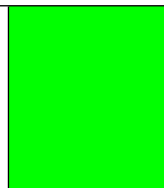
This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews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

Staff turnover since previous audit has been identified as stable with relatively low turnover.

Two of the five previous audit findings have been addressed relating to progress notes and medication administration. Further improvements continue to be required around timeliness of documentation, interventions and implementation of care.

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.

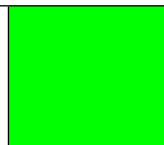


Standards applicable to this service fully attained.

Discussions with families identified that they are fully informed of changes in health status. 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.



Standards applicable to this service fully attained.

The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities, including Radius key performance indicators, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings are held regularly, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An education and training programme has been implemented with a current plan in place. An orientation programme is in place for new staff. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care. Residents and families report that staffing levels are adequate to meet the needs of the residents.

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>
---	--	---

Care plans are developed by the registered nurses on a newly implemented computerised system. RNs also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate. The medication management system in place follows appropriate administration, signing and storage practices and each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the activities coordinator. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

Safe and appropriate environment

<p>Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.</p>		<p>Standards applicable to this service fully attained.</p>
---	--	---

A current building warrant of fitness is displayed.

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.
---	--	--

The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there were three residents with restraints (bed rails) and seven residents using an enabler (five bed rails and two lap belts).

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.
---	--	--

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	3	0	0
Criteria	0	41	0	0	3	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints policy and procedure is in place. The complaints procedure is provided to residents and their family within the information pack at entry. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings and complaint forms. Complaint forms are available at reception. Thirteen complaints were received in 2017. A review of the complaints register evidences that the appropriate actions have been taken and the complainant received documented outcome of the complaint.</p> <p>An additional complaint made through the Health & Disability Commissioner (HDC) in 2017 was investigated and followed up. Arran Court are awaiting a response to a follow-up letter in September 2017. Following an anonymous complaint to the Ministry of Health, HealthCERT had requested that the complaint be followed up at this audit. This audit found all of the issues raised were unsubstantiated. Interviews with staff confirmed cultural respect, support and training also covered cultural safety.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Six residents (four rest home [including one YPD] and two hospital) interviewed, stated they were welcomed on entry and were given time and explanation about the services and procedures. Ten incident reports reviewed evidenced recording of family notification. Three relatives (one rest home and two hospital) interviewed, confirmed they are notified of any changes in their family member's health status. Monthly resident meetings provide a forum for residents to discuss issues or concerns. Families are encouraged to visit. The facility has an interpreter policy to guide staff in accessing interpreter services. Arran Court has a number of younger people including residents on</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>YPD contracts. These residents' communication methods are available through social media and networks.</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 Arran Court Rest Home and Hospital has a total of 102 beds. All beds are dual-purpose. At the time of the audit there were 99 beds occupied, 41 residents were rest home level including two residents on a long-term support chronic health conditions contract (LTSCHC). Fifty-eight residents were hospital level including one resident on a LTSCHC contract and one resident on respite. Eight of the 99 residents were on the younger persons with disability (YPD) contract (three rest home level and five hospital level).</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 2017/2018 for 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 (RN) who has worked in aged care for the past 15 years. She holds a bachelor's degree with a postgraduate diploma in education. She has been in the role for three and a half years. She is supported by a regional manager (who was present during the days of the audit). The clinical manager role is currently vacant, and a roving clinical manager was working in the role until the position is filled). There is a clinical team leader.</p> <p>The facility manager has maintained at least 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 management system that reflects continuous quality improvement</p>	<p>FA</p>	<p>There is an organisational business plan that includes quality goals and risk management plans for Arran Court. Quality and risk performance is reported across facility meetings and to the regional manager. The facility manager advised that she is responsible for providing oversight of the quality programme. There is a monthly staff meeting where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff. Required actions and resolutions from facility meetings are consistently documented. Resident meetings are monthly. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The overall service result for the resident/relative satisfaction survey completed in July 2017 was at 98%.</p> <p>The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The clinical operation managers group, with input from facility staff, reviews the service's policies at national level every two years. Clinical guidelines are in place to assist care staff. The quality monitoring programme is designed to monitor contractual and standards compliance</p>

<p>principles.</p>		<p>and the quality of service delivery in the facility and across the organisation. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. 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. The health and safety representatives (maintenance person and kitchen hand) interviewed confirmed their understanding of health and safety processes. Both have completed the external health and safety training in November 2017. 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 Workplace Safety Management Practice. Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions.</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. Incidents are included in the Radius key performance indicators (KPI). There is a discussion of incidents/accidents at monthly staff and quality/health and safety meetings including actions to minimise recurrence. A review of ten incident/accident forms identified that forms are fully completed and include follow-up by a RN. Not all neurological observations are carried out as per protocol for any suspected injury to the head (link 1.3.6.1). Discussions with the facility manager and regional manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There had been three section 31 notifications made since the last audit. All were for pressure injuries; in July 2017 (unstageable pressure injury), in November 2017 (grade three pressure injury) and in December 2017 (unstageable pressure injury).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one clinical team leader, two RNs, two healthcare assistants (HCA) and one activities coordinator) include a comprehensive recruitment process, which included reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals. A register of RN staff and other health practitioner practising certificates is maintained. Registered nurses are supported to maintain their professional competency.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. Staff are required to</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>complete written core competencies during their induction. These competencies are repeated annually. 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. Seven of thirteen RNs have completed their interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. There is a full-time facility manager, relieving clinical manager and a clinical team leader who work from Monday to Friday. There facility is split into three wings; Bethells, Piha and Karekare.</p> <p>In Bethells, there are 34 residents in total (8 rest home and 26 hospital) there is one RN on duty in the morning shift and afternoon shift, and night shift. They are supported by six HCAs (three long and three short-shifts) on the morning shift, five HCAs (two long and three short-shifts) on the afternoon shift and one HCA on the night shift. The majority of the younger people were situated together in this wing.</p> <p>In Piha, there are 34 residents in total (23 rest home and 11 hospital) there is one RN on duty in the morning shift, afternoon shift, and night shift. They are supported by four HCAs (two long and two short-shifts) on the morning shift, three HCAs (two long and one short-shift) on the afternoon shift and one HCA on the night shift.</p> <p>In Karekare, there are 30 residents in total (10 rest home and 20 hospital) there is one RN on duty in the morning shift and afternoon shift, and night shift. They are supported by six HCAs (three long and three short-shifts) on the morning shift, five HCAs (two long and three short-shifts) on the afternoon shift and one HCA on the night shift. There is an additional HCA on the night shift who floats between the three wings.</p> <p>Residents and family members interviewed report there are sufficient staff numbers. Interviews with seven caregivers and three RNs, identify that staffing is adequate to meet the needs of residents and that any replacement staff required due to absenteeism are always replaced.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded,</p>	<p>FA</p>	<p>The residents' files were appropriate to the service type. A locked room stores archived residents' files. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. 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 reflected documentation in the same section of the residents' files and are in a chronological order. This previous finding has now been addressed.</p>

current, confidential, and accessible when required.		
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>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</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>	FA	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented. The service uses a packaged system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Short-life medications (i.e., eye drops and ointments) are dated once opened.</p> <p>Education on medication management has occurred with competencies conducted for the RN and senior HCAs with medication administration responsibilities. Administration sheets sampled were appropriately signed. Twelve medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. This previous finding has now been addressed. A RN was observed administering medications and followed correct procedures. No residents self-administer medicines. The registered nurse interviewed explained that none of the younger people are able to self-medicate currently, but it is something that they would enable if possible depending on the resident.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids</p>	FA	<p>The service continues to provide a high standard of meal services. Varied menus to reflect resident tastes and needs are provided (e.g., puree meals and vegetable curry for a resident who prefers this meal). 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</p>

<p>and nutritional needs are met where this service is a component of service delivery.</p>		<p>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 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The service is in the process of implementing a computer-based care planning system and all of the resident care plans and files are now transferred over to the new software, including the six resident files reviewed. The assessment process for the software and the interRAI process are not aligned and this has led to inconsistencies in the care plan. The service has recognised this, and comprehensive handovers are in place (viewed) to ensure that residents receive appropriate care. HCAs interviewed were well informed regarding resident care needs. Care plans reviewed evidence multidisciplinary involvement in the care of the resident. Care plan interventions remain a shortfall from the previous audit.</p> <p>Short-term care plans are in use for changes in health status and are evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if an ongoing problem. There is evidence of service integration with documented input from a range of specialist care professionals including: the podiatrist, physiotherapist, dietitian and mental health care team for older people. The care staff advise that the care plans are easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Care plans sampled were goal orientated (link 1.3.5.2). The staff interviewed stated that they have sufficient equipment and supplies to provide care. Equipment was sited including sufficient disposable gloves and PPE.</p> <p>Three residents with wounds were reviewed for this audit and one pressure injury. Assessments, management plans and documented reviews were in place for all wounds. All wounds had associated short-term care plans and an incident form had been documented as part of the software package. One wound was infected, and this was reflected in to the infection control log.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist is available two days during the week to assist with mobility assessments and the exercise programme.</p> <p>Monitoring records sighted included weights, neurological observations, food and fluids and turning charts. Not all monitoring had been documented according to care plan instruction. Monitoring is a continued finding from the previous audit.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</p>
<p>Standard 1.3.7:</p>	<p>FA</p>	<p>There are two staff employed (two activity coordinators) who are responsible for the planning and delivery of the individual and group activities programme with assistance from staff. There are organised activities for seven hours</p>

<p>Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>per day, five days per week.</p> <p>Two 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 RNs, 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 programme.</p> <p>Activities are planned following feedback from the monthly resident's meetings. The activities person informs that at least one of the activities for each session is planned with younger people in mind. The younger resident interviewed said that they are happy with the activities and there is always lots to do. Community linkages are well documented both with van trips into the town and bus trips for the more able.</p> <p>A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.</p> <p>The service has its own van for transportation. Residents interviewed described van outings, musical entertainment and attendance at a variety of community events. On the day of audit there was much merriment due to a bed making competition between the staff and residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents are reassessed using the interRAI and computer based assessments (link to 1.3.3.3 for timeframes). Long-term care plans are then evaluated and updated. There was documented evidence that care plan evaluations were current in resident files sampled. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested, if issues arise or their health status changes. The RNs interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>FA</p>	<p>There is a current building warrant of fitness expiring 8 December 2018.</p> <p>The service has equipment to assist mobilisation such as hoists. Access to the service is enabled with ramps to external areas. Residents were witnessed accessing the outside and gardens in mobility chairs.</p>

for their purpose.		
<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	The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. Residents and relatives interviewed were happy with the cleaning
<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	Infection surveillance is an integral part of the infection control programme and is described in the Radius 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 onto 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.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there was three residents with restraints (bed rails) and seven residents using an enabler (five bed rails and two lap belts). All necessary documentation is available in relation to the restraints. Staff training has been provided around restraint minimisation in May 2017. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.

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 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely</p>	<p>PA</p> <p>Moderate</p>	<p>The service is implementing a new computer software based assessment and care planning process. The interRAI process has also been implemented. The two processes have not always been undertaken at the same time and interRAI assessments were not always documented in a timely manner. The service has an action plan and is working to align all processes. The previous finding around meeting timeframes remains an area for improvement.</p>	<p>Not all assessments are undertaken in a timely manner, including one hospital resident whose interRAI was not always completed six monthly, one rest home resident who did not have an updated interRAI or updated computer assessments on return from a hospital stay.</p>	<p>Ensure that interRAI assessments are documented according to timeframes and that timeframes for computer software assessments align to the interRAI.</p>

meet the needs of the consumer.				60 days
<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>	PA Moderate	<p>Care plans are in place for all residents. These are entered into the computer software programme. Staff inform that they are able to easily access the care plans as there are nine computer stations. Not all resident information is up-to-date. This is a continued finding from the previous audit.</p>	<p>Three of four hospital (including one YPD) files did not include all interventions to guide resident care. Examples include; (i) The YPD resident did not have up-to-date interventions regarding toileting and use of continence products; (ii) One hospital resident file documented walking in the garden when they no longer mobilize. (iii) One hospital level resident had contradictory information regarding mobilizing, and did not include rotation of analgesia patches. Management techniques were not documented to manage medication and care for assisted withdrawal of alcohol. This resident did not have a trial of puree diet documented to encourage eating meals.</p>	<p>Ensure that care plans include interventions to support all assessed resident needs.</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>	PA Moderate	<p>Overall identified resident assessed needs were documented in the care plans sampled (link 1.3.5.2), and staff interviewed were familiar with the care requirements for each resident. Care plans sampled included monitoring requirements. Not all monitoring forms reviewed had been fully documented as instructed by the care plan or identified that monitoring was completed in a timely manner. The previous finding around implementation of care has not been fully addressed.</p>	<p>Monitoring was not consistently documented for two of four hospital files including one YPD files reviewed; (i) One resident had no documented effectiveness of analgesia (as required by the care plans); (ii) one YPD resident had repositioning documented hourly, but had remained up to seven hours on his back.</p>	<p>Ensure monitoring is undertaken and documented according to policy and care plan instruction.</p> <p>30 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.