

Radius Residential Care Limited - Althorp

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: Althorp

Services audited: Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

Dates of audit: Start date: 8 February 2018 End date: 9 February 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: 97

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Radius Althorp is part of the Radius Residential Care Group. Althorp cares for up to 117 residents across four service levels (dementia, hospital, psychogeriatric and rest home level care). On the day of the audit there were 97 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, staff and general practitioner.

The facility is managed by a registered nurse experienced in aged care. The manager has been in the role for two years and has experience in aged care management. She is supported by an experienced clinical manager who has been at Althorp for 18 months, an assistant facility coordinator and the Radius regional manager.

Residents and family interviewed spoke positively about the service provided.

Two of the three shortfalls identified at the previous audit have been addressed. These were around medication and restraint management. Improvement continues to be required around implementation of care.

This audit has identified additional improvements are required around timeliness of interRAI assessment.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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There is evidence that residents and family are kept informed. 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.
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Services are planned, coordinated and are appropriate to the needs of the residents. A facility manager is responsible for the day-to-day operations of the facility. Quality and risk management processes are maintained. Strategic plans and quality goals are documented and regularly reviewed. Corrective action plans are implemented where opportunities for improvement are identified. A risk management programme is in place, which includes a risk management plan and robust health and safety processes. Human resources are managed in accordance with good employment practice and meeting legislative requirements. An orientation programme is in place for new staff. Education is provided for staff. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

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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Care plans are developed by the registered nurses who 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, and they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. 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 diversional therapist. 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>
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There is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has alternative systems available so that staff can use restraint as a last resort strategy. There were no residents using restraint, three residents voluntarily using bedrails and one resident using a lap belt as enablers on the day of the audit. Care plans include reference to the use of enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Radius Althorp has an infection control programme that complies with current best practice. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	1	1	0	0
Criteria	0	38	0	1	1	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>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are accessible to residents and family. Information about complaints is provided on admission. Interviews with four residents (three hospital level and one rest home level) and family members confirmed their understanding of the complaints process. Care staff interviewed (five healthcare assistants, five registered nurses and one activities coordinator) were able to describe the process around reporting complaints.</p> <p>Verbal and written complaints received are recorded on an electronic complaint register. There is evidence that these complaints have been managed in a timely manner including acknowledgement, investigation, meeting timelines, corrective actions when required and resolutions. One complaint received via the Health and Disability Commissioner in 2016 evidenced a comprehensive investigation of issues and the development of a corrective action plan. Most aspects of the complaint have been resolved with evidence of ongoing communication with two respondents. This complaint led to a DHB audit in December 2016. Corrective actions identified from that audit have been addressed.</p> <p>A sample of the forty-three complaints received from 2016 and 13 complaints from 2017 were reviewed. A review of the complaints registers evidences that the appropriate actions have been taken in the management and processing of these complaints. Complaints are linked to the quality and risk management system.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that is not covered by the agreement. Regular contact is maintained with family including if an incident or care/health issues arises. Eleven families (four from the hospital, four from dementia and three from the psychogeriatric unit) interviewed stated they were kept well informed. Twelve incident/accident forms and related progress notes were reviewed and identified that the next of kin were contacted, or if not, justification as to why. Residents' meetings are held quarterly.</p> <p>The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</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 Althorp is part of the Radius Residential Care Group. Althorp provides care for up to 117 residents across four service levels (hospital, dementia, psychogeriatric and rest home level care). Althorp has four DHB funded palliative care beds and three funded respite beds (one secure dementia and two hospital level care beds).</p> <p>The service is divided across six units. There are 57 hospital beds across two hospital units (Rueben and McLeod units). There are five rooms in the hospital unit that can be used as dual-purpose. There was one rest home resident and 45 hospital residents including one on a young person with disabilities contract (YPD), two residents on palliative care contracts and two residents on respite contracts.</p> <p>There is a 15-bed dementia wing (Church unit) with 14 residents including one respite resident.</p> <p>There are three psychogeriatric units (Best, Scott, and Munro), each unit has 15 beds each. There is a total of 37 residents across the three units.</p> <p>The Althorp business plan April 2017 to March 2018 is linked to the Radius Care Group strategies and business plan targets. The mission statement is included in information given to new residents. An organisational chart is in place. Comprehensive monthly and quarterly reviews are undertaken to report on achievements towards meeting business goals.</p> <p>The facility manager began employment in the role in November 2015, having previously managed aged care services. She is supported by an experienced clinical nurse manager and the regional manager.</p> <p>The facility manager has maintained more than 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 principles.</p>	<p>FA</p>	<p>An established quality and risk management system is embedded into practise. 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. A document control system is in place. Policies are regularly reviewed, and new or revised policies are made available for staff to read and sign that they have read and understand the changes.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data is comprehensive. Data is collated and benchmarked against other Radius facilities. Quality and risk data, including trends in data and benchmarked results are discussed in the quality and applicable staff meetings. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are established, implemented and are signed off by management when completed. Caregivers and RNs interviewed were aware of the corrective actions and described receiving toolbox education sessions on falls prevention, moving and handling and skin care.</p> <p>A resident satisfaction survey is conducted each year. Results for 2017 reflected high levels of resident satisfaction with the services received and where shortfalls were identified, a corrective action plan was implemented.</p> <p>Processes are in place for accident and incident reporting, injury prevention and management, workplace inspections and hazard management. Health and safety goals are established and regularly reviewed. Health and safety policies are implemented and monitored by the Health and Safety Committee. A health and safety representative (maintenance supervisor) was interviewed about the health and safety programme. A quality initiative using the work place safety management programme has been implemented by the facilities physiotherapist. Risk management, hazard control and emergency policies and procedures are being implemented. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme.</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention equipment includes sensor mats, perimeter guards and chair alarms.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	<p>FA</p>	<p>The service collects data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information into 'Ecase' (electronic resident management system). The reporting system is integrated into the quality and risk management programme. Once incidents and accidents are reported, the immediate actions taken are documented on 'Ecase' and a message sent to the registered nurses and clinical nurse manager (CNM). A total of 14 incidents were reviewed, all included registered nurse follow up. The clinical nurse manager (CNM) reviews and investigates the incident. If risks are identified, these are processed as hazards and the hazard register updated.</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>A discussion with the facility manager has confirmed her awareness of statutory requirements in relation to essential notification. Two section 31s were completed for pressure injuries.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of health professionals are current. Eight staff files were reviewed (three healthcare assistants, the clinical manager, two registered nurses, a housekeeper and the activities coordinator). Evidence of signed employment contracts, job descriptions, orientation and training were available for sighting. Newly appointed staff complete a comprehensive orientation that is specific to their job duties. Interviews with care staff described the orientation programme that includes a period of supervision. Files of two recently employed staff confirmed a comprehensive orientation had been completed as per requirements. Annual performance appraisals for staff were completed in files sampled.</p> <p>There are 39 healthcare assistants employed across the PG and dementia units. Thirty-six have completed the required dementia unit standards. Three caregivers are in the process of completing and all have been employed for less than six months (two staff have recently commenced at Radius Althorp).</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented, and attendance is recorded. Focused tool box talks are implemented in response to corrective actions generated from internal audits, complaints and survey results. All in-service and toolbox talks are evaluated by the attendees and evidence increased knowledge and understanding. Staff complete a range of competency assessments including (but not limited to) hoist and manual handling, hand hygiene, restraint and medication where relevant. Registered nurses also complete (but not limited to) wound management, and Nikki T pumps.</p> <p>Twelve of 22 registered nurses have completed their interRAI training and a further three are currently training. There is always a staff member on duty with a current first aid/CPR certificate.</p> <p>Training includes (but not limited to) Death and Tangihanga May 2017. Dementia, delirium and challenging behaviour training was last provided July 2017.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Both the facility manager and the clinical manager are registered nurses (RN's). A minimum of two RN's are rostered on duty 24 hours a day, 7 days a week. The service is divided into six separate units (three</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>psychogeriatric, one secure dementia and two hospital).</p> <p>At least one RN is rostered in each of the hospital units (Rueben unit includes 27 hospital beds and McLeod unit includes 30 hospital beds) on morning and afternoon shifts. There is one rest home resident in McLeod unit. Night shift is covered by one RN across the two hospital units. In each of the hospital units on morning shift there are three HCA's on long shifts and two on shorter shifts. On the afternoon shift in each of the hospital units there are two long shifts and two short shifts. There are three HCA's covering both hospital units on night shift.</p> <p>The psychogeriatric units (Best, Scott, and Munro) have 15 beds each. There is three RNs across the three units on morning shifts, three RNs on afternoon shifts and one RN across the three units on night shift. An experienced enrolled nurse works a flexi morning shift during the week across Best and Scott units. Best and Scott units have HCA's working four long shifts and two short shifts on mornings and two long and two short shifts in the afternoon. Munro unit has two HCA long shifts and one short shift on morning, one long and one short on afternoons and one HCA at night shift.</p> <p>Residents, family and the GP expressed concern regarding staffing and the layout of the facility. The roster evidenced expected staffing standards and the DHB contracts are met. In discussion with the management team there is an undertaking to review staffing utilisation and staffing levels. Staff and relatives reported there was good access to a RN at all times.</p> <p>The 15-bed secure dementia unit (Church unit) has two HCA long shifts and one short shift on morning, one long and one short on afternoons and one HCA on night shift. The unit is supported by one of the RNs in the PG unit.</p> <p>The roster is able to be changed in response to resident acuity.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. Medication rooms were reviewed from each of the six units (16 medication charts). All residents have individual paper-based medication charts with photo identification and allergy status documented.</p> <p>The service uses a four-weekly 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. Medication orders included indications for use of 'as needed' medicines. Short-life medications (i.e., eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior healthcare assistants with medication administration responsibilities. Administration sheets sampled were appropriately signed. 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. All medications were prescribed, this is an improvement on the previous audit. A registered nurse was observed administering medications and</p>

		followed correct procedures. No residents self-administer medicines.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a fully functional kitchen and a contracted company cooks all food 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 require 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>All units have a variety of food available over the 24-hour period and staff reported the kitchen manager is very responsive to special requests.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Moderate	<p>Eight resident files were reviewed – three hospital including one resident younger person disabled (YPD), one rest home resident, two secure dementia level residents, including one respite and two psychogeriatric level residents. Care plans sampled were goal orientated but did not document all care needs.</p> <p>The YPD resident file reviewed documented that the resident and her family were consulted on all aspects of care. Community links were available (but the resident chose not to join). The dementia level respite resident file reviewed had a documented care plan in place and also an interRAI assessment as they were transferring to long-term care. The care plan included a well-documented Māori care plan.</p> <p>The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary.</p> <p>The service currently is managing two pressure injuries. Both reviewed had fully documented management plans, assessments and reviews. A sample of wounds were reviewed across all areas. Specialist nursing advice is available from the DHB as needed. The service documents all wounds though the computer care planning system. Shortfalls were identified around wound documentation. This is a continued finding from the previous audit. Care plans reviewed of residents with a current wound did not all document interventions to reflect a wound (or a short-term care plan).</p> <p>A physiotherapist is available full time to assist with mobility assessments and the exercise programme.</p> <p>Monitoring records sighted such as food and fluids were consistently completed but not always behaviour and turning charts.</p>

		Residents and family members interviewed confirmed their satisfaction with care delivery.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service has four activities staff, one of whom has completed diversional therapy (DT) training and is waiting for registration. The staff educator is also a trained DT.</p> <p>There are organised activities for seven days per week. Caregiving staff also provide activities over the weekends.</p> <p>Each service level (dementia, hospital and psychogeriatric) have their own activity programme. Residents often join each other's programme according to preference. Activity staff report that a number of one-on-one activities is provided for residents in at hospital level. Four relatives (hospital level care) agreed that individualised activities for their relatives was very good.</p> <p>Residents in the dementia and psychogeriatric units all have 24-hour activity plans in place. During the audit activities were observed to be consistently provided in the units and that many residents went to other units for activities.</p> <p>One YPD was observed to have a range of activities available within easy reach in resident's room. The resident said that she goes out with family and this was also documented.</p> <p>Group activities were provided in the lounges, in seating areas and outdoors in the gardens when weather permits. Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance.</p> <p>The group activities programmes are developed monthly, and a copy of the programme is available in the lounge and on noticeboards. The group programme includes residents being involved within the community with social clubs, churches and schools.</p> <p>The activity person interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop a diversional therapy plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process.</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>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	FA	<p>Residents are reassessed using the interRAI process and using computer-based assessments (link to 1.3.3.3). There was documented evidence that care plan evaluations were current in resident files sampled.</p> <p>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 registered</p>

<p>evaluated in a comprehensive and timely manner.</p>		<p>nurses 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 (link 1.3.6.1).</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is prominently displayed and reactive and preventative maintenance occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance of infection data assists in evaluating compliance with infection control practices. Monthly infection data is collected for all infections based on signs and symptoms of infection. All individual resident infections are entered into an electronic resident management system including 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 where benchmarking is completed. This data is reported to the facility quality, clinical and staff meetings. Monthly graphs were displayed in staff areas. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The use of restraint is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked. There is a regional restraint group at the organisational level and a restraint group at the facility where restraint is reviewed.</p> <p>There were no residents using restraints on the day of audit. There were three residents with enablers in the form of bed rails. These were requested by the residents. The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of one of the files of a resident using an enabler.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Each episode of restraint and enablers is monitored at pre-determined intervals depending on individual risk to that resident. Documented evidence that monitoring of enablers has been completed and this is an improvement since previous audit.</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>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	The service requires that both interRAI assessments and computer-based assessments are completed for all residents, both on admission, six monthly and as needed. Resident files documented that computer-based assessments (which drive the care plan content) had been updated as specific areas of need had changed. Not all assessments and interRAI had been completed according to timeframes.	(i)One rest home resident did not have an interRAI (or updated computer assessments) following a hospital stay, (ii) one psychogeriatric resident did not have interRAI within 21 days of admission or 6 monthly (or computer-based assessments).	Ensure that interRAI assessments are documented in a timely manner 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are	PA Moderate	Staff interviewed reported they receive good clinical leadership. The clinical nurse manager who has been in the role for 18 months, was observed to be very involved in care. Staff	(i) Two of 18 wounds reviewed (psychogeriatric and hospital) were not evaluated/redressed according to timeframes. (ii) Three of 18 wounds	(i)-(ii) Ensure that wound care plans are documented and

<p>consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>interviewed were observed to be caring and knowledgeable about individual care need. They praised the support and guidance from the senior leadership team. Relatives stated that all care was extremely good. All residents had a care plan documented and handovers were observed to be in-depth.</p> <p>A sample of wounds were reviewed across all areas. The service documents all wounds though the computer care planning system. Shortfalls were identified around wound documentation. This is a continued finding from the previous audit. Further shortfalls were identified around monitoring, and care plan interventions reflecting interventions to support current wounds.</p>	<p>reviewed (two psychogeriatric and one hospital) did not have a fully documented management plan for the wound. (iii) Three care plans reviewed of residents with a current wound did not all document interventions to reflect a current wound (or a short-term care plan completed).</p> <p>(vi) One resident in dementia care had documented behaviours in progress notes that were not documented on the behaviour monitoring chart; (v) one hospital level resident did not have two hourly turns documented as per the care plan; (vi) one resident in hospital level care did not have catheter changes documented according to set timeframes.</p>	<p>evaluated/redressed as per timeframes;</p> <p>(iii) Ensure care plans include interventions to acknowledge and support current wounds;</p> <p>(iv)-(vi) Ensure that all monitoring and care interventions are documented as undertaken according to the care plan.</p> <p>60 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.