

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

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## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Radius Residential Care Limited
<b>Premises audited:</b>	Radius Arran Court Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 21 June 2018    End date: 22 June 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	97



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

## 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 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 and staff.

This surveillance audit was completed as a follow up from a previous surveillance audit completed early 2018. This audit identified the three previous shortfalls around timeliness of documentation, interventions and wound monitoring continue to require improvement.

A further improvement was identified at this audit around medication management.

## 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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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.
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The quality and risk management programme includes service philosophy, goals and a quality planner. There is a monthly quality/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. 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. There is an annual education/training schedule for 2018 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>
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Care plans are developed by the registered nurses on an 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. There is a documented medication management system. Resident medication charts are 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 reported 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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A current building warrant of fitness is displayed. The building and surroundings are well maintained and provide a safe and accessible environment suited to the resident's needs.

## 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.

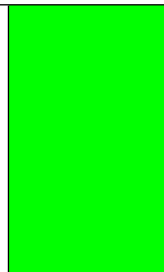


Standards applicable to this service fully attained.

The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there were four residents with restraints and seven residents using an enabler.

## 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)
<b>Standards</b>	0	13	0	0	4	0	0
<b>Criteria</b>	0	39	0	0	4	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. A complaint's register includes written and verbal complaints, dates and actions taken. Three complaints have been made since the last audit. One of the complaints received has been documented as resolved with the complainant signing off that they were satisfied with the outcome. Two recent complaints received are documented as still open with investigations still ongoing.</p>
<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>Seven residents (four rest home [including one YPD] and three 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. Four relatives (two 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</p>

		<p>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 YPD contracts. A number of processes could be described around supporting younger residents with communication.</p>
<p><b>Standard 1.2.1: Governance</b></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. All beds are dual-purpose. At the time of the audit there were 97 beds occupied, 43 residents were rest home level including one resident on a long-term support chronic health conditions contract (LTS-CHC) and one resident on respite care on an (POAC) contract. Fifty-four residents were hospital level, including one resident on a LTS-CHC contract. Eight of the 97 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>There is an acting facility manager, who is a registered nurse (RN) that has been in the role since March 2018 and will be until the position is filled. The acting facility manager has worked for Radius for a year having previously worked as a regional manager for nine months. 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 is working (four-five days a week) in the role until the position is filled. There are also two clinical team leaders; both were away on leave at the time of the audit.</p> <p>The acting facility manager has completed at least eight hours of professional development activities related to managing an aged care facility.</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</p>	FA	<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 acting facility manager advised that she is responsible for providing oversight of the quality programme. There is a monthly quality/staff meeting where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff. Required actions and</p>

<p>principles.</p>		<p>resolutions from facility meetings are consistently documented. Resident/relative meetings are monthly. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The annual resident/relative satisfaction survey for Arran Court is due in July 2018. The overall service result for the resident/relative satisfaction survey for 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 services 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 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 representative (maintenance person) interviewed confirmed their understanding of health and safety processes. He has completed the external health and safety training in November 2017. Risk management, hazard control and emergency policies and procedures are in place. There is an up-to-date annual hazard register in place that was last reviewed in July 2017. 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 for May 2018 identified that forms were fully completed and included follow-up by a RN. All neurological observations were</p>

		<p>carried out as per protocol for any unwitnessed falls with potential head injury. Discussions with the acting facility manager and regional manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 notification made since the last audit. The notification was for a stage three pressure injury in March 2018.</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. Six staff files reviewed (one clinical team leader, two RNs, two health care assistants (HCA) and one activities coordinator) 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 complete written core competencies during their induction. These competencies are repeated annually. There is an annual education/training schedule for 2018 in place which is being adhered to. 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. Five of ten RNs employed 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>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. There is a full-time acting facility manager, a roving clinical manager (four-five days a week) and two clinical team leaders (one is full-time, and one works three days as a clinical team leader and two days as an RN). Interviews with seven caregivers identify that staffing is adequate to meet the needs of residents and that any replacement staff required due to absenteeism are replaced.</p> <p>The facility is split into three wings; Bethells, Piha and Karekare. In Bethells, there are 34 of 35 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. The RNs are supported by six HCAs (three long and three short-shifts) on the morning shift, four HCAs (two long and two short-shifts) on the afternoon shift and one HCA on the night shift. Five of the eight YPD residents are situated together in Bethells wing.</p>

		<p>In Karekare, there are 29 of 33 residents in total (11 rest home and 18 hospital), there is one RN on duty in the morning shift and afternoon shift, and night shift. The RNs are supported by five HCAs (three long and two short-shifts) on the morning shift, four HCAs (two long and two short-shifts) on the afternoon shift and one HCA on the night shift.</p> <p>In Piha, there are 34 of 35 residents in total (24 rest home and 10 hospital) there is one RN on duty in the morning shift and afternoon shift, the RN in Karekare covers the night shift. The RNs 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. The two residents on LTSCHC contracts are situated in Piha wing. There is an additional HCA on the night shift who floats between the three wings. Residents and family members interviewed reported there are sufficient staff numbers.</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>PA Moderate</p>	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. The system is paper-based and uses robotic sachets. All residents have individual medication orders with photo identification and allergy status documented. 'Indications for use' were not always documented for 'as required' medications. All medicines are stored securely when not in use in one of the three treatment rooms. However, medication fridge monitoring has not been consistently completed. 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. The service does not have vaccines on-site.</p> <p>Education on medication management has occurred with competencies conducted for the RN and senior HCAs with medication administration responsibilities. All RNs have a current syringe driver competency and syringe drivers have been checked and calibrated. 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. A RN was observed administering medications and followed correct procedures. No 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>All food preparation is done in the commercial kitchen on-site. Varied menus to reflect resident tastes and needs are provided (eg, puree meals and meals that meet cultural preferences). 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 (link 1.3.3.3 re timeframes). The kitchen can 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 company 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 1.3.5: 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 uses a computer-based care planning system and all the resident care plans and files are on the new software. The six care plans were populated from a series of assessments in the electronic software and then individualised by the RN completing the care plan. There are comprehensive handovers in place (sighted) to ensure that residents receive appropriate care. HCAs interviewed were well informed regarding resident care needs. Six of six care plans sampled did not include interventions to support all identified needs. Care plan interventions remain a shortfall from the previous audit. 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.</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 did not have interventions to support all resident's needs (link 1.3.5.2). However, the staff interviewed stated that they have sufficient equipment and supplies to provide care and were familiar with the residents and their required cares. Equipment was sighted, including sufficient disposable gloves and PPE. There are 15 current wounds, all minor in nature. There were no pressure injuries at the time of the audit. Assessments, management plans and documented reviews were in place for all wounds but not always documented within timeframes. All wounds had associated short-term care plans and an incident form had been documented as part of the software package.</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. Monitoring records sighted included weights, neurological observations, food and fluids and turning charts. Not all monitoring had been documented according to care plan interventions. Efficacy is not documented for pain and behaviour monitoring. Monitoring is a continued finding from the previous audit. Residents and family members interviewed confirmed their satisfaction with care delivery.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There are two experienced activities 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 per day, five days per week. 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 residents' 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. 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. The service has its own van for transportation. Residents interviewed described van outings, musical entertainment and attendance at a variety of community events.</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>Residents are reassessed using the interRAI and computer-based assessments. Long-term care plans are then evaluated and updated (link to 1.3.3.3 for timeframes). 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</p>

		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>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>There is a current building warrant of fitness expiring 8 December 2018. Preventative maintenance is scheduled, and reactive maintenance is carried out as required. Electrical testing has been completed and medical equipment has been calibrated. The environment and buildings are well maintained. Corridors are wide enough and allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. There are several outside courtyard areas with seating and tables and umbrellas available. Pathways, seating and grounds appear well maintained.</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>	FA	<p>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 acting facility manager. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. At the time of the audit there were four 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 April 2018.</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)
<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 guidelines.</p>	<p>PA Moderate</p>	<p>There is a treatment/medication room with a medication trolley in each of the three wings. All medication, including stock medications are within the expiry date. Eye drops are dated. There is a medication fridge in each medication/treatment room and these have not been monitored daily as required by Radius policy. All medication charts had been completed by the residents GP (residents continue with their previous GP) and eight of the twelve had indications for use documented for ‘as required’ medications.</p>	<p>(i) Each of the three medication fridges had periods of up to nine days when temperatures had not been monitored. (ii) Four of twelve medication charts reviewed did not have ‘indication for use’ documented for ‘as required’ medications.</p>	<p>(i) Ensure medication fridges are monitored according to Radius policy. (ii) Ensure all ‘as required’ medications have the indication for use documented.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment,</p>	<p>PA Moderate</p>	<p>The service is implementing a computer software based assessment and care planning process. The interRAI process</p>	<p>Three of three residents (two hospital and one rest home) that required an interRAI assessment, did</p>	<p>Ensure that contractual timeframes are met for resident documentation.</p>

<p>planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>has also been implemented and electronic assessments are completed at similar times and both feed into the care plan (link 1.3.5.2). This aspect of the previous shortfall has been addressed. InterRAI assessments and care plan evaluations were not always documented in a timely manner. The previous finding around meeting timeframes remains an area for improvement.</p>	<p>not have these completed within 21 days of admission. Two of these files (one rest home and one hospital) had not had care plan evaluations completed within the required six-month timeframe. One hospital level resident did not have an interRAI assessment completed when they had a significant change in needs.</p>	<p>60 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Electronic care plans are in place for all residents. These are entered into the computer software programme. Staff inform that they can easily access the care plans as there are nine computer stations. Not all resident information is current and not all assessed needs were evidence in care plan interventions. This is a continued finding from the previous audit.</p>	<p>Intervention shortfalls were identified in all six care plans reviewed sampled. (i) Resident A (Hospital): The care plan did not reflect all interventions to support assessed needs around mobility, continence, pain and ADLs. (ii) Resident B (Hospital): The care plan included contradictory information around cognition and does not include interventions to support continence. (iii) Resident C (hospital): The care plan was not updated to address improved mobility or daily physiotherapy requirements. (iv) Resident D (Hospital): The dietitian's instructions were not in the care plan; the use of dietary supplements was not in the care plan and the requirement for two hourly turns and de-escalation techniques interventions were not in the care plan. (v) Resident E (Residential disability receiving rest home level care): The care plan does not address de-escalation techniques.</p>	<p>Ensure that care plans include interventions to support all assessed resident needs.  60 days</p>

			(vi) Resident F (Rest home): The care plan had not been updated following physiotherapy review and there were no interventions for pain other than analgesia.	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Overall it was identified that resident assessed needs were not well documented in the care plans sampled (link 1.3.5.2), but staff interviewed were familiar with the care requirements for each resident. Care plans sampled included monitoring requirements. Monitoring forms did not document the efficacy of interventions. This previous shortfall continues to require addressing. All 15 current wounds are minor and have an assessment, plan and timeframe for review documented. However, the timeframes are not always met. The previous finding around implementation of care has not been fully addressed.</p>	<p>(i) Seven of the 15 current wounds had not been reviewed within the stated timeframe. (ii) Three of three pain monitoring charts reviewed, and two of two behaviour monitoring charts did not document the effectiveness of the interventions used.</p>	<p>(i) Ensure all wounds are reviewed within the stated timeframe.</p> <p>(ii) Ensure the effectiveness of interventions is documented.</p> <p>30 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.