

Radius Residential Care Limited - Radius Arran Court Rest 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 BSI Group New Zealand Ltd, 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: 24 September 2020 End date: 25 September 2020
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:	88



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 and hospital (medical and geriatric) and residential disability - physical level care. On the day of the audit there were 88 residents.

The service is managed by an experienced facility manager. She is supported by a Radius regional manager and a clinical manager. Residents and relatives spoke positively about the service provided.

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

The shortfall identified at the previous audit around discrepancies between interRAI and the care plan has been addressed.

This audit has identified one area for improvement around completion of neurological observations after residents had had an unwitnessed fall or have hit their head.

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 residents and relatives confirmed that residents, and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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A facility manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded in practice. Results are shared with staff. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The diversional therapist implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness. Reactive and preventative maintenance occurs.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures being implemented for the safe assessment and review of restraint and enabler use. A register is maintained. During the audit there were three residents were using an enabler and five residents were using a restraint.

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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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

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	16	0	0	1	0	0
Criteria	0	42	0	0	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>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission.</p> <p>Interviews with 10 residents (3 rest home and 7 hospital [including 3YPD]) and relatives confirmed their understanding of the complaints process with examples provided. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register that includes complaints received, dates and actions taken. The facility manager signs off each complaint when it is closed. Two complaints were reviewed during the audit. Complaints reviewed were being managed in a timely manner as per policy.</p> <p>One complaint had been received from the Health and Disability Commission since the last audit. Corrective actions requested by the HDC have been completed. These included a completion of an audit of patient records. A written apology was sent to the resident's family for its breach of The Health and Disability Commissioner Health and Disability Services Consumers' Rights (the Code). A written update on the steps taken to address the issue identified in the HealthCERT audit report regarding the care plans not reflecting the interRAI assessments was sent as requested.</p> <p>The Ministry of Health requested an update on the steps taken to address the issues identified in the HealthCERT audit inspection. This audit confirmed that the interRAI assessments and care plans are now</p>

		<p>reflective of resident needs.</p> <p>The complaints process is linked to the quality and risk management system with trends identified and corrective actions implemented. There is evidence of lodged complaints being discussed in the staff meetings.</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>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the electronic system. All 10 accidents/incidents reviewed met this requirement with family notified of any incident. Family members interviewed (three hospital and one rest home) commented that they are notified following a change of health status of their family member or if there had been an incident.</p> <p>Family/resident meetings provide a venue where issues can be addressed.</p> <p>There is an interpreter policy in place and contact details of interpreters were available. At the time of the audit, there were 14 residents who were limited in their ability to understand English. Staff and family are used as interpreters in the first instance. The regional manager reported that interpreter services through the DHB have been used in the past and are available if needed. Communication information sheets are laminated and made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Radius Arran Court Rest Home and Hospital has a total of 102 beds and is certified for rest home, hospital (including medical) and residential disability - physical. All beds are dual-purpose.</p> <p>At the time of the audit there were 88 beds occupied. On the day of audit, there were 32 residents at rest home level, which included one resident on an interim funding programme (IFP) contract, one long-term support - chronic health condition contract (LTS-CHC) and 4 younger persons with disability (YPD) residents.</p> <p>There were 56 residents at hospital level of care including two residents on a long-term support - chronic health condition contract (LTS-CHC) and 6 YPD residents. All beds are dual-purpose. Residents not under a specific contract identified, are under the Age-Related Care Contract.</p> <p>The Radius Care strategies 2018-2021 describe the vision, values, and objectives of Radius aged care facilities. The 2020 -2021 business plan is specific to Radius Arran Court and describes specific and measurable goals that are regularly reviewed and updated.</p> <p>The facility manager has 30 years management experience in aged care. She was appointed to this role in November 2019. She is supported by a regional manager (who was present during the audit) and a clinical</p>

		<p>nurse manager. The clinical nurse manager has been in the role for two years.</p> <p>The facility manager and clinical manager have 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 principles.</p>	<p>FA</p>	<p>An established quality and risk management system is embedded into practice. Quality and risk performance are reported in staff meetings and to the regional manager. Discussions with the managers and staff reflected the staff's involvement in quality and risk management processes. Residents including those under the YPD contract, also have input into quality improvements and regularly attend the monthly resident meetings.</p> <p>Annual resident and relative surveys were last completed in July 2020 with a positive response. Results were collated and discussed with staff. No trends were identified.</p> <p>The service has policies and procedures and associated implementation systems, adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level every two years. Clinical guidelines are in place to assist care staff.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are guidelines and templates for reporting. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff in meetings and on staff noticeboards.</p> <p>Corrective action plans are implemented when opportunities for improvements are identified (eg, internal audit results are lower than 95%, and partially attained criteria from previous audits). Corrective actions are evaluated and signed off when completed. Quality improvement plans (QIPs) are developed where opportunities for improvements are identified.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. The health and safety officer (administration officer) was interviewed about the health and safety programme. She has completed health and safety training (stages one, two and three). Risk management, hazard control and emergency policies and procedures are in place. The hazard register was last reviewed on in November 2019. There are procedures to guide staff in managing clinical and non-clinical emergencies.</p> <p>Falls prevention strategies are in place including assessing those residents who are at risk of falling. Sensor mats, perimeter mattresses and intentional-rounding practices are implemented to reduce falls.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed electronically for each incident/accident with action(s) noted and any follow-up action(s) required.</p> <p>A review of 10 accident/incident forms identified that forms are fully completed and include follow-up by a registered nurse and sign-off by the clinical manager. Accident/incident forms are completed when a pressure injury is identified. Neurological observations are not always completed for any suspected injury to the head (link 1.3.6.1).</p> <p>The facility manager and regional manager were able to identify situations that would be reported to statutory authorities including (but not limited to): infectious diseases, serious accidents, and unexpected death. The DHB and Ministry of Health were notified of the new manager using a section 31 form.</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>Human resources policies include recruitment, selection, orientation, and staff training and development. Ten staff files reviewed (one clinical nurse manager, one clinical team leader (registered nurse), three RNs, three healthcare assistants, one activities coordinator, one facility manager) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice and includes a system for determining staff competency across a range of topics (eg, falls prevention, communication, restraint, basic cares/observations, aging process, infection control, informed consent). There is an implemented annual education and training plan that meets contractual requirements. 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. Performance appraisals were up-to-date in the staff files reviewed of staff who had been employed for one year or longer.</p> <p>Registered nurses are supported to maintain their professional competency. Four registered nurses and the clinical nurse manager have completed their interRAI training. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale.</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>The rest home unit (Piha wing) has 18 rest home and 10 hospital level residents. It is staffed with one RN and three healthcare assistants (HCAs) (two long shift, one short shift) on the AM and PM shifts.</p> <p>Hospital A (Bethells wing) has 8 rest home and 24 hospital level residents. It is staffed with one RN on the AM and PM shifts and six HCAs (three long shift and three short shift) on the AM shift and four HCAs (two long and two short) on the PM shift.</p> <p>Hospital B (13 rest home and 18 hospital) is staffed the same as hospital A.</p> <p>The night shift is staffed with two RNs and four HCAs that cover the entire facility.</p> <p>The facility manager reported that staff turnover has been moderate, especially for registered nurses. Absenteeism was high at the last audit but since the appointment of the new facility manager, this has settled. Agency staff are used to fill absences.</p> <p>Staff were observed attending to call bells in a timely manner. Staff interviewed stated that overall, the staffing levels are satisfactory.</p> <p>Residents and family 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>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were three residents self-administering on the day of audit. A consent form had been signed and the resident deemed competent to self-administer. The inhalers and creams were in a drawer. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses a paper based and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs administer all medications in the hospital. Medication competent HCAs administer medications in the rest home. Staff attend annual education and have an annual medication competency completed. Four RNs are syringe driver trained by the hospice. The medication fridge and room temperatures are checked weekly. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the medication signing sheets. Twelve medication charts were reviewed (eight hospital and four rest home). Medications are reviewed at least three-monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	<p>FA</p>	<p>The service has a kitchen manager and a chef who work full time. There is a cook who covers weekends and holidays. There are five kitchenhands who cover all shifts. All cooks have current food safety</p>

<p>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>certificates. The kitchen manager oversees the procurement of the food and management of the kitchen.</p> <p>There is a well-equipped kitchen, and all meals are cooked on site. Meals are served in each area from bain maries or hot boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The four weekly menu cycle is approved by a dietitian. All residents/families interviewed were satisfied with the meals.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. The previous shortfall identified at the certification audit around documentation of interventions has been addressed. Interventions documented now always match the information in interRAI, and the detail required to support needs and guide care is in place as per plan.</p> <p>Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialists and professionals including the podiatrist, dietitian, and mental health care team for older people. The care staff interviewed advised that the care plans were 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>	PA Moderate	<p>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed.</p> <p>Resident falls are reported on electronic incident forms and written in the progress notes. Neurological observations are taken when there is a head injury or for an unwitnessed fall, but these are not always completed as per policy.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Electronic wound assessment, wound management and wound evaluation forms are in place for all wounds.</p>

		<p>Wound monitoring occurs as planned. There are currently 22 wounds being treated. There are currently fourteen pressure injuries. Six are stage one and eight are stage two. Pressure injury equipment is available and is being used. HCAs document changes of position electronically. The GP and wound care nurse specialist are involved as required. The service has implemented a quality initiative around minimising pressure injuries and continually reviewing the effectiveness of strategies.</p> <p>Electronic monitoring forms are in use as applicable such as weight, vital signs, and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>
<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>	<p>FA</p>	<p>There is one diversional therapist who works 37.5 hours a week, one activities assistant who works 37.5 hours a week and one activities assistant who works 22 hours a week. On the day of audit residents were observed listening to a newspaper reading, participating in a quiz, and playing games.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Every Monday each resident is given a copy of the weekly programme to keep in their room if they wish. Residents have the choice of a variety of activities, in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, bingo, news from the paper, music, quizzes, and games. There is happy hour weekly and weekly walks in the garden (including wheelchairs). There is a knitting club.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There is an interdenominational church service fortnightly and Catholic communion every Sunday.</p> <p>Each area has a van outing weekly. Special events like birthdays, Easter, Mothers' Day, Anzac Day, and the Melbourne Cup are celebrated. The residents often have afternoon tea under the trees in summer. There are weekly entertainers.</p> <p>There is monthly pet therapy and recently the residents were able to watch chicken eggs hatching in an incubator.</p> <p>There is community input from the local preschools and schools as well as the RSA. There are outings to other Radius facilities for bowls and outings to events such as the orchid show.</p> <p>There are ten YPD residents. They are included in any activities they wish to join. One is a keen member of the knitting club and also goes out independently. One goes to stroke club. One goes out shopping weekly and has nails and hair done in the community. One is kept busy with many art projects. The facility pays for Netflix so YPD residents have more up to date shows to view.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that</p>

		<p>describes the residents past hobbies and present interests, career, and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Resident meetings are held monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Except for the IFP resident, all plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem.</p> <p>Activities plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP, and resident/family if they wish to attend.</p> <p>There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness which expires 3 December 2020. There is a call bell system in all resident areas. The facility is well equipped with hoists, wheelchairs, and transfer belts. There is ample space to use this equipment safely. Both internal and external areas are safe.</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>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have generally been low. Trends are identified and quality initiatives are discussed at staff and infection control meetings. Definitions of infections are in place appropriate to the complexity of service provided. Systems are in place that are appropriate to the size and complexity of the facility. A pandemic plan is in place and there is sufficient PPE available.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that</p>	FA	<p>The clinical nurse manager is the designated restraint coordinator. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of</p>

<p>the use of restraint is actively minimised.</p>		<p>restraints and enablers.</p> <p>There were five residents using restraint (restraint included lap belt, a high/low bed with a mattress on the side and bed rails) and three residents using bedrails and/or lap belt as an enabler during the audit.</p> <p>One resident file of a resident using an enabler (bedrails) was reviewed. The resident gave written consent for the use of bedrails. The enabler was linked to the resident's care plan and was regularly reviewed.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</p>
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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 1.3.6.1</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</p> <p>Moderate</p>	<p>When a resident has an unwitnessed fall, or a head injury neurological observation are expected to be taken as per policy. There is a policy around neurological observations, however this could be strengthened to clarify expectations for staff.</p>	<p>Eight of ten electronic incident forms reviewed (for unwitnessed falls or head injuries) did not show evidence of completion of neurological observations as per policy.</p>	<p>Review the neurological observation policy and ensure all neurological observations are completed as per the policy.</p> <p>90 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.