

# Radius Residential Care Limited - Radius Rimu Park

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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 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 Rimu Park

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

**Dates of audit:** Start date: 15 April 2021 End date: 16 April 2021

**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:** 52

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Radius Rimu Park is owned and operated by Radius Residential Care Limited and cares for up to 55 residents requiring, hospital (medical and geriatric), rest home or specialist hospital (psychogeriatric) level care. On the day of the audit there were 52 residents.

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 resident and staff files, and observations and interviews with residents, relatives, staff, management, and a general practitioner.

The facility manager is appropriately qualified with extensive experience in aged care including management experience and education in management of challenging behaviour. The clinical manager and regional manager both support the facility manager and staff. There are quality systems and processes being implemented with quality projects showing that improvements continue to be made. The residents and relatives interviewed spoke very highly about the care and support provided.

The shortfall identified at the last certification audit around taking of neurological observations when a resident has an unwitnessed fall or has hit their head with evidence of opportunities to minimise future occurrences has been met.

This audit has identified a shortfall around completion of clinical documentation (care plans and interRAI assessments) in a timely manner.

## 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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Management operates an open-door policy with a rapid response to residents or family who have queries or who wish to raise concerns. Residents and relatives are kept informed on all aspects of their health including accidents/incidents. Complaints and concerns have been managed appropriately and an up-to-date complaint register is maintained.

## 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 facility and clinical managers are both registered nurses and they are supported by registered nurses and care support staff. The quality and the risk management programme include activities and corrective action plans focused on improving service delivery and practice. Facility meeting minutes' evidence discussion around key performance indicators and quality and risk management data. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through.

A comprehensive education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Knowledgeable and skilled staff are rostered onto shifts including staff trained specifically trained to support residents in the psychogeriatric unit.

## Continuum of service delivery

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.		Some standards applicable to this service partially attained and of low risk.
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The registered nursing staff are responsible for each stage of service provision. The assessments and long-term care plans are developed in consultation with the resident/family/whānau. The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents.

The activities team have developed an activity programme to promote resident independence, involvement, emotional wellbeing, and social interaction appropriate to the level of physical and cognitive abilities of the rest home, hospital, and psychogeriatric care residents.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies. The medication charts meet prescribing requirements and had been reviewed at least three-monthly.

Food services and all meals are prepared on site. Resident's individual food preferences and dislikes are known by kitchen staff and those serving the meals. There is dietitian review of the menu. Choices are available and are provided, with nutritious snacks being available 24 hours per day.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness and all external areas were accessible and of an appropriate standard. There is a preventative and planned maintenance schedule in place. Ongoing maintenance issues are addressed. The psychogeriatric unit is secure.

## 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 restraint minimisation and safe practice policies and procedures in place. There were eight residents requiring the use of a restraint and five using an enabler. The service is focused on maintaining a safe environment. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme include policies, standards, and procedures to guide staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff and residents are offered the annual flu vaccine. There has been one outbreak since the previous audit.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	15	0	1	0	0	0
<b>Criteria</b>	0	40	0	1	0	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 facility, clinical and regional managers were interviewed during the audit along with five healthcare assistants (HCA), two registered nurses, a cook, activities coordinator, one maintenance staff. All stated that they had completed training around the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility, next to the suggestions box. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process.</p> <p>A complaint register includes complaints received, dates and actions taken. The facility manager signs off each complaint when it is closed. Complaints since the previous audit included two complaints received in 2020 and three complaints in 2021 year to date. One complainant was supported by the Health and Disability Commissioner (HDC) nationwide advocate. Complaints are being managed in a timely manner; meeting requirements determined by the HDC. There is evidence of lodged complaints being discussed in the quality meetings, clinical and staff meetings (where applicable). The log of complaints noted that all complainants were satisfied with the outcome of the investigations and responses made.</p>
Standard 1.1.9:	FA	There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>required to record family notification when entering an incident into the system. All 17 adverse events reviewed met this requirement when notification was appropriate.</p> <p>Family members interviewed (one from the rest home, three from hospital and two from the psychogeriatric unit) confirmed they are notified following a change of health status of their family member. There have been family/resident meetings in 2020 and 2021 with the Health and Disability Nationwide Advocate invited to attend. Minutes reviewed indicated that these were well attended. There is an interpreter policy in place and contact details of interpreters were available.</p> <p>Eight residents were interviewed. These included one from rest home level of care, five from hospital and two under an ACC contract (hospital level of care). All residents and family interviewed stated that they had been kept well informed during the Covid 19 pandemic.</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 Rimu Park is a Radius aged care facility located in Whangarei. The facility is certified to provide hospital (medical and geriatric); rest home and psychogeriatric care for up to 55 residents. Residents living at the facility during the audit totalled 52 on the day of audit. There are 35 dual purpose bedrooms with nine residents at rest home level and 26 at hospital level on the day of audit (three are under an ACC contract). There is a 20-bed psychogeriatric unit with 17 residents occupying beds during the audit including one under an ACC contract.</p> <p>The business plan describes the vision, values, and objectives of Radius Rimu Park. Goals are linked to the business plan. Goals are reviewed a minimum of three-monthly and the business plan is updated annually.</p> <p>The facility manager is an experienced RN, who has extensive training and experience in management of a psychogeriatric unit with three years in the current role. They have worked for 10 years in an intensive care unit in mental health services, has worked as a clinical nurse educator in the DHB and in disability services for 11 years. The facility manager has been in the role since March 2018. The facility manager is supported by a clinical manager/registered nurse (RN) who has been in the role for three years, has experience in aged care services for four years, and has 15 years' experience in surgical services. The Radius regional manager supports the management team.</p> <p>The facility manager and clinical manager have both completed in excess of eight hours of professional development activities related to managing an aged care facility in the past 12 months. The facility manager brings experience and enthusiasm in providing education and direction around caring for people with very challenging behaviours. Feedback from residents, relatives and staff and the GP was extremely positive.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>There is a business plan 2020-2021 with monthly reviews completed. This is developed by the facility manager and team. An established quality and risk management system is embedded into practice with a quality plan documented and implemented. Quality and risk performance is reported across facility meetings and to the regional</p>

<p><b>Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>manager. Discussions with the managers (regional manager, facility manager and clinical manager) and staff, reflected staff involvement in quality and risk management processes.</p> <p>Resident and family meetings are at least two-monthly. Minutes are maintained. An annual resident survey in August 2020 with a 20% return rate (noting that this was circulated during the Covid 19 pandemic). The report showed that 90% of respondents would recommend the service to others, 100% felt welcome, and 100% of respondents stated that they were neutral or very satisfied with information and communication provided. Where opportunities were identified for improvement, these have been acted on.</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 Radius clinical managers group with input from facility staff reviews the service's policies 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 clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data with opportunities taken to improve service delivery. Results are communicated to staff in meetings (monthly staff meetings, monthly quality meetings including health and safety, monthly restraint meetings and monthly registered nurse meetings) and on staff noticeboards. Corrective action plans are implemented when opportunities for improvements are identified (e.g. when internal audit results are lower than 95%). Corrective actions are signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. A health and safety representative (maintenance staff) was interviewed about the health and safety programme. The maintenance staff member has completed external health and safety training and was able to describe their role as per policy, a job description and legislation. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>Falls prevention strategies are in place with a quality initiative called the "PIE" approach (preserve environmental integrity) whereby there are HCAs designated as watchers in the psychogeriatric units. Falls are kept as low as possible over the past two months as a result of the PIE initiative. Prevention strategies are implemented when a resident has two or more falls. Strategies include sensor mats, perimeter mattresses and impact mats.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p>	<p>FA</p>	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</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>They are signed off by the clinical manager when complete.</p> <p>A review of 17 accident/incident forms identified that forms are fully completed and include follow-up by a registered nurse. Accident/incident forms are completed when a pressure injury is identified. Neurological observations are implemented for all unwitnessed falls with observations completed as per policy. The service also uses the information collected through the process to improve service delivery and to minimise future occurrences. The shortfall identified at the previous audit has been addressed. The facility and clinical managers are involved in the adverse event process.</p> <p>The facility manager and regional manager were able to identify situations that would be reported to statutory authorities including infectious diseases, serious accidents, and unexpected death. There has been one requirement to report to the Ministry of Health on a Section 31 since the last audit for a pressure injury. The DHB was notified of an outbreak of scabies.</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. There has been a moderate turnover of HCAs however registered nurses are now stable. The turnover rate of all staff has decreased since the last audit.</p> <p>Six staff files reviewed (one clinical manager, two RNs, three HCAs) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction. These competencies are scheduled to be repeated annually.</p> <p>There are 18 HCAs employed to work in the psychogeriatric wings with 10 having completed their NZQA dementia qualification and four HCAs in the process of completing their qualification. A careerforce assessor has been appointed to start up toolbox talks to support staff. There are currently 15 with level one training (CareerForce) completed, eight HCA with level two training, four with level three training completed. There is intensive training on an ongoing basis around management of challenging behaviour for all staff with the facility manager facilitating this. The facility manager has previous experience in tertiary level training in this area. The GP interviewed stated that staff were well trained and supported to manage resident needs and particularly to manage challenging behaviours.</p> <p>There are 12 registered nurses and three casual RNs who are supported to maintain their professional competency. Three registered nurses have completed their interRAI training. There are implemented competencies for registered nurses including medication competencies and insulin competencies.</p>

		Performance appraisals are completed within three months of commencing and annually thereafter.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. There is a minimum of one RN each shift covering the hospital/rest home unit and one RN covering each shift in the psychogeriatric unit. They are supported by a team leader in the psychogeriatric unit and a clinical manager. There is a registered nurse rostered to complete interRAI assessments over and above RNs rostered on to shifts for two-three days a week.</p> <p>Staffing in each unit is as follows:</p> <p>Psychogeriatric unit: Currently 17 of a potential 20 residents in two wings. There is a registered nurse on duty 24 hours per day. On morning shift, there are three healthcare assistants who work a full shift. On the morning shift there is a HCA 'float' who works between the psychogeriatric unit and the rest home/hospital. On afternoon shifts, there are three healthcare assistants who work a full shift, and a lounge watch who works from 3PM to 7PM. On night shift there is one HCA and a HCA 'float' who works between the psychogeriatric unit and the rest home/hospital. There is flexibility to add additional shifts to the night shift if required with sign off from the facility manager.</p> <p>Combined hospital and rest home unit (nine rest home level residents and 26 hospital): There is a registered nurse on duty 24 hours per day supported by experienced care staff. On each of the morning and afternoon shifts there are four healthcare assistants who work a full shift. There are two HCAs on duty overnight.</p> <p>There is a full-time activities staff, one newly appointed activities coordinator who works three and a half days a week and one part time qualified diversional therapist who shares their time between Radius Rimu Park and another Radius facility.</p> <p>There is a physiotherapist that is contracted on an 'as required' basis.</p> <p>There is a GP that visits twice weekly and as required.</p> <p>The call bell system has been upgraded and staff were observed attending to call bells in a timely manner. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents interviewed reported there are sufficient staff numbers.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive</p>	FA	<p>Policies and procedures are in place for safe medicine management. Medications are stored safely in the medication rooms. Registered nurse who administers medications have been assessed for competency on an annual basis and attend annual medication education. Registered nurses have completed syringe driver training. All medication sachets are checked on delivery against the medication charts.</p>

<p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>One resident at rest home level of care was self-administering medication on the day of the audit. The resident was assessed as being competent and was asked daily if they had taken their medication. Policies and procedures for residents self-administering are in place and this includes ensuring residents have safe storage for their medications. The medication fridge is checked as per policy, and temperatures are maintained within the acceptable temperature range. All eye drops sighted in the medication trolleys were dated on opening.</p> <p>Two medication rooms were checked including one in the psychogeriatric unit. Ten paper-based medication charts were reviewed and met prescribing requirements. Medication charts had photo identification and allergy status notified. The GP had reviewed the medication charts three monthly. 'As required' medications had prescribed indications for use. There are no vaccines kept on site.</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>The food services are overseen by a kitchen manager. All meals and baking are prepared and cooked on site by kitchen staff. Food services staff have completed food safety training.</p> <p>The seasonal menu is reviewed by a dietitian and rotates four-weekly, with summer and winter menus. The kitchen manager receives resident dietary profiles and is notified of any dietary changes for residents. Dislikes and special dietary requirements are accommodated including food allergies and gluten free diets. Pureed/soft meals are provided. The kitchen is adjacent to the hospital/ rest home dining room. Food is probed for temperature and transferred to the psychogeriatric wing by a hot box and served hot. For those residents having meals in their room's meals are transported by hot boxes to resident rooms. Snacks are available for all residents 24 hours a day from the kitchenettes.</p> <p>The Food Control Plan expires on 27 April 2021. Freezer, fridge and end-cooked, re-heating (as required), cooling and serving temperatures are taken and recorded daily. All perishable foods and dry goods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Chemicals were stored safely.</p> <p>Residents provide feedback on the meals through resident meetings and resident survey. The cook receives feedback directly both verbally and through resident meetings. Residents and relatives interviewed spoke positively about the choices and meals provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. Family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant.</p> <p>Care plans reflect the required health monitoring interventions for individual residents. Monitoring charts are well utilised. A care activity worklog is generated for HCAs and registered nurses with scheduled tasks and monitoring charts including repositioning, bowel chart, behaviour chart, food and fluid chart, weight, blood pressure monitoring,</p>

<p>in order to meet their assessed needs and desired outcomes.</p>		<p>blood sugar levels, neurological observations, and toileting regime. Family is notified of all changes to health as evidenced in the electronic progress notes.</p> <p>There were 27 wounds and two pressure injuries being treated on the day of the audit. The wounds comprised of 17 skin tears, eight scrapes/abrasions/scratch, one cellulitis, and one blister. The pressure injuries comprised of one facility acquired stage two pressure injury (now healing), and one initially unstageable non-facility acquired pressure injury with this now assessed as a stage three pressure injury. Wound assessments had been completed on eCase for all wounds and for pressure injuries. The GP is involved with clinical input for wounds and pressure injuries and the wound care specialist nurse is accessed as required. Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources. A continence specialist can be accessed as required.</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>	<p>FA</p>	<p>The activities programme is managed by a qualified diversional therapist who works part time. There are two activities coordinators work Monday to Friday. The programme is integrated (the activities team spread their time across both the rest home/hospital and psychogeriatric unit) from Monday to Friday. There are separate activity programmes occurring in both the rest home/hospital (Rimu) wing and the psychogeriatric wing (Manuka). Residents receive a copy of the programme which has set daily activities and additional activities, entertainers, outings, movies, and visits from the community. Activities have been set up in Manuka so residents can participate in them at any time. One-on-one activities such as individual walks and chats occur for residents who are unable to participate in activities or choose not to be involved in group activities.</p> <p>A resident lifestyle assessment is completed soon after admission. Leisure plans were seen in resident electronic files. The activity team are involved in the six-monthly review of resident's care plan with the registered nurse. The service receives feedback and suggestions for the programme through resident meetings (rest home and hospital and psychogeriatric) and surveys. The residents and relatives interviewed were happy with the variety of activities provided.</p> <p>A van is available for outings. Outings have included visits into the community. In addition, and when required residents are taken to appointments.</p> <p>Activities in place for residents in the PG area cover activities and usual routines across 24/7. The activities team and healthcare assistants provide these activities.</p>
<p><b>Standard 1.3.8:</b></p>	<p>FA</p>	<p>Initial care plans for long-term residents were evaluated by the registered nurses within three weeks of admission. Long-term care plans have been evaluated by the RN six monthly or earlier for any health changes in the electronic</p>

<p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>resident files reviewed (link 1.3.3.3). Family are invited to have input into the resident's service delivery plans. Written evaluations reviewed, identified if the resident goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes.</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>The building holds a current warrant of fitness which expires 1 June 2021. The maintenance manager works full-time. Maintenance requests are recorded on eCase and the maintenance manager checks this each working day and signs them off when repairs have been completed. The planned maintenance schedule includes electrical testing and tagging, resident equipment checks, calibrations of weigh scales and clinical equipment. Monthly hot water tests are completed for resident areas. Essential contractors/tradespeople are available 24 hours as required. A grounds-person maintains the gardens and grounds.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas, courtyard and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. A new roof has just been put on the building.</p> <p>The large internal courtyard in the psychogeriatric unit has recently been refurbished. The psychogeriatric unit is secure.</p> <p>Registered nurses and HCAs interviewed stated they have adequate equipment to safely deliver care for rest home/hospital and PG level of care residents.</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>Infection surveillance is an integral part of the infection control programme and is described in Radius' infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual electronic 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 infection control meetings and placed on the staffroom noticeboard. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There has been one outbreak of scabies since the previous audit. The service has sufficient personal protective equipment to manage in the event of an outbreak for at least two weeks. Staff have had training around Covid 19 and procedures to manage any outbreak.</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 facility 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 restraints and enablers.</p> <p>There are five rest home residents using enablers (all bedrails). The residents using enablers have given written consent for the use of bedrails.</p> <p>Eight residents were using restraint during the audit (seven lap belts were in use including two for residents in the PG unit and five in the rest home) and four bedrails (three in the rest home and one in the PG unit).</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 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	The policy around assessment and care planning provides guidelines for the completion of initial documentation for a new resident. Two of the five resident records reviewed had an initial interRAI assessment completed in a timely manner and one of the five had an initial care plan completed in a timely manner as per policy.	(i). Three of the four resident records reviewed did not have an initial interRAI assessment completed in a timely manner. (ii). Four of the five resident records did not have an initial care plan completed in a timely manner as per policy.	<p>(i). Ensure the initial interRAI assessment is completed as per policy/contract. (ii). Ensure an initial care plan is documented in a timely manner as per policy.</p> <p>90 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.