Radius Residential Care Limited - Radius Waipuna

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Radius Residential Care Limited
Premises audited:	Radius Waipuna
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: 7 June 2018 End date: 7 June 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 69

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
	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

Radius Waipuna currently provides rest home, hospital (medical and geriatric) and residential disability (physical) level care for up to 86 residents. On the day of audit there were 69 residents.

This 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, observations and interviews with residents, relatives, staff and management.

The service has recently experienced a period of change in the management team, resulting in a number of shortfalls being identified by the regional and facility managers. A corrective action/short-term business plan has been developed and implemented with regular review and sign off as issues have been addressed.

The audit identified that the three shortfalls identified at the previous partial provisional audit around completing the interior of the building and landscaping and having an operational call bell system have been addressed.

This audit identified improvements are required around care planning and performance appraisals. The service has been awarded a continuous improvement rating around the activities programme.

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.

Radius Waipuna practices open disclosure with residents and family reporting they are well informed. Complaints processes are implemented and there is a complaint's register.

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.		Some standards applicable to this service partially attained and of low risk.

Radius has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process has recently begun to be implemented after a gap and includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Residents and relatives are provided the opportunity to feedback on service delivery issues at resident meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents have been collated monthly. Radius has job descriptions/positions that include the role and responsibilities of the position. Appropriate staff training has been provided and staff are supported to undertake external training. The service has a documented rationale for determining staffing and health care assistants, residents and family members report staffing levels are sufficient to meet resident needs.

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 medium or high risk and/or unattained and of low risk.

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 demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners/nurse practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior health care assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the general practitioner/nurse practitioner.

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.

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.

The facility has a current warrant of fitness and provides a safe and suitable environment.

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.

Staff receive training around restraint minimisation and the management of challenging behaviour. During the audit, four residents were using restraints and four residents were using enablers. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

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 type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical manager is the infection control coordinator who is responsible for the collation of infections. 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	1	15	0	1	1	0	0
Criteria	1	39	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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 six residents (three rest home and three hospital) and relatives, confirmed their understanding of the complaints process. Staff interviewed (including five health care assistants (HCAs), six registered nurses including three-unit coordinators, the diversional therapist and a cook) were able to describe the process around reporting complaints. A complaint's register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in manager and staff meetings. Eighteen of the 19 complaints received in 2017 and 2018 year-to-date have been documented as resolved, with appropriate corrective actions implemented. Management continue to work with the other complainant. A complaint was received via the DHB on 30 May 2017. Radius Waipuna replied on 31 May 2017, acknowledging the complaint and the required reporting timeframe.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	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 system. Twelve of thirteen adverse events reviewed met this requirement. One resident did not have any family to contact. Seven family members interviewed (one rest home, four hospital and two younger persons with disabilities), confirmed they are notified following a change of health status of their family member. The service and other external providers ensure the younger residents that require communication aids have these provided. There is an interpreter policy in place and contact details of interpreters were available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Radius Waipuna provides rest home, hospital (geriatric and medical) and residential disability (physical) for up to 86 dual-purpose rooms. On the day of the audit there were 69 residents. Seventeen residents were receiving rest home level care (fourteen under the ARCC contract, three residents under respite). There were 52 residents receiving hospital level of care (25 residents on an ARCC contract, four residents under the long-term chronic health contract (LTS-CHC), three resident on ACC and two resident on dual-funding by ACC and MSD, and 18 YPD residents including two respite). The service underwent a significant period of change when the three managers (facility, clinical and reception) resigned and left between June and August 2017. Relieving managers and clinical managers were contracted while the recruiting process was undertaken. Between November 2017 and April 2018, processes including quality processes were not fully completed. A corrective action plan to address all shortfalls identified by the new facility manager, the receptionist (who returned to the facility in April 2018) and the regional manager has been used as a living business plan since April 2018. The plan has been regularly reviewed and the majority of shortfalls identified by the service have been addressed or are in progress. The facility manager is a registered nurse with previous aged care (clinical manager) experience and has been in the role for six months. She is supported by a clinical manager (CM) that has been recently employed and the Radius regional manager. The CM was a registered nurse at Waipuna before stepping up into the CM role. The facility manager and CM have not had aged care management experience. Both underwent a comprehensive orientation and are closely mentored

		by the regional manager. The facility manager has maintained at least eight hours annually of professional development activities related to managing a hospital.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Radius has established quality and risk management policies and procedures which are being implemented at Waipuna. There was a period between November 2017 and April 2018 when quality activities were not fully completed. All activities have been completed retrospectively for the missing period, where this was possible and feasible. No partial attainment has been raised around this as the issue has been addressed. Prior to November 2017 and since April 2018 an established quality and risk management system has been embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the managers and staff reflected staff involvement in quality and risk management processes. Resident meetings are monthly. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. The residents survey in 2017 and a food survey in 2018 both resulted in corrective action plans which have been implemented and are closed except for ongoing monitoring. Results are communicated to staff across a variety of meetings and reflected actions being implemented and signed off when completed. 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 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. Policies and procedures include the requirements to meet the needs for younger people. 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 established processes to collect, analyse and evaluate data, which is utilised for service improvements (gaps noted between November 2017- April 2018 have been addressed). When service shortfalls are identified a corrective action plan is raised, implemented and signed off. Active and closed corrective action plans (including the service wide corrective action plan/business plan) were sighted for identified shortfalls.

		Health and safety policies are implemented and monitored by the health and safety committee. The health and safety representatives interviewed, confirmed their understanding of health and safety processes including current law requirements. They have completed the external health and safety training and ongoing updates. 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. Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions.
Standard 1.2.4: Adverse Event Reporting 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.	FA	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. A review of 13 incident/accident forms identified that forms were fully completed and include follow-up by a registered nurse. Neurological observations where required have been carried out two-hourly for any suspected injury to the head. The clinical manager is involved in the adverse event process. All incident forms sampled had been reviewed to identify ways to minimise recurrence. The regional manager was 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 were notified the week prior to the audit around staffing issues and a section 31 notification has been made for a pressure injury.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files reviewed (the clinical manager, one registered nurse, two healthcare assistants and the diversional therapist) included a comprehensive recruitment process, which included reference checking, signed employment contracts and job descriptions, police checks, and completed orientation programmes, but not annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe

		work practice. Staff training had been inconsistently completed between November 2017 and April 2018. This was identified, and a corrective action plan developed, which included all staff attending a series of two-hour training sessions to ensure all areas missed between November and April 2018 had been covered. These had been completed by the time of the audit. There is an annual education and training plan that exceeds eight hours annually and the manager reports the service will transition back to this now that missed training has been completed. The clinical manager holds overall responsibility for staff education. There is an attendance register for each training session and an individual staff member record of training. The in-service programme has included specific training around caring for younger people including (but not limited to); cultural safety, Code of Rights, spirituality, sexuality and intimacy, and communication. Registered nurses are supported to maintain their professional competency. Four registered nurses (one is the clinical manager and one is the facility manager) have completed their interRAI training. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	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 on-site at any time. Activities are provided five days a week. The facility manager and regional manager report staffing is adjusted according to acuity and staff interviewed confirmed this. For the purpose of rostering and cares, the service is divided into two equal areas. On the day of the audit one wing had 35 residents – nine rest home level and 26 hospital residents and the other had eight rest home level residents and 26 residents receiving hospital level care. Staffing for each wing was the same at the time of the audit: On AM shifts, there is one RN and four HCAs 7.00 am to 3.00 pm and two HCAs from 7.00 am to 1.30 pm and one from 7.00 am to 1.00 pm. On the PM shift, there is one RN and four HCAs from 3.00 pm to 11.00 pm, two HCAs from 3.00 pm to 9.30 pm and one HCA from 4.00 pm to 9.00 pm on a flexi shift. On night shift there is one RN and three HCAs all working full shifts. (At occupancy of 75 and over, dependent on acuity, the service will add either a 2nd

		RN or level 3 or 4 HCA). Staff working on the days of the audit, were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders in use. 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 and senior medication competent HCAs administer medications. All staff administering medications have up-to-date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked weekly. Eye drops are dated once opened. Staff sign for the administration of medications. Twelve medication charts were reviewed (including one respite care). Medications are reviewed at least three monthly by the GP or NP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The service has two cooks and two kitchenhands who cover all shifts between them. All have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are taken to the dining rooms in hot boxes and served by the HCAs. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well-presented. 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. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were documented electronically. The four-weekly menu cycle is

		approved by a dietitian. All residents interviewed stated that the meals could be improved and that they were working on this through the residents' committee.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. This included the RN's, GP/NP and DT. There was also input from the physiotherapist if she had been involved with the resident. All care plans are resident centred. However, shortfalls were identified around care plan interventions. 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 and reviews. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, physiotherapist, wound care specialist and the dietitian. The HCAs interviewed advised that the care plans were easy to follow, and they particularly liked the care plan summaries.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the registered nurse initiates a GP or NP 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. Care plans have been updated as residents' needs changed. Resident falls are reported on accident forms and written in the progress notes. Family are notified of falls. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. If management are asked for extra supplies and equipment this is made available. Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently 43 wounds being treated (twenty minor skin tears, two surgical wounds, seven scrapes and abrasions, one puncture wound, nine blisters, three stage one hospital acquired pressure injuries and one venous ulcer). The RN's complete all wound dressings and all wound documentation. The chronic venous ulcer has had input from the GP and wound care nurse specialist. The HCA's stated that they are aware of pressure injury risk and turn residents two hourly if required. Turning charts are used. There is pressure area prevention equipment such as air mattresses available. 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.

Standard 1.3.7: Planned Activities 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.	CI	There is one diversional therapist who works 40 hours a week Monday to Friday. There is also an activities assistant who works 25 hours a week. On the days of audit residents were observed participating in exercise and 'Happy Hour', playing balloon games and skittles and listening to entertainment from a visiting duo. There is a weekly programme in large print on noticeboards and all residents have a copy in their rooms. 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, Tai Chi, games, quizzes, music, arts and crafts, brain teasers, and aromatherapy. There is a card, golf, bowling and men's group. 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. There are fortnightly church services held in the facility and the Catholic priest comes in to give communion every Friday. There are van outings every week. Separate van outings for YPD residents include outings to shops, cafés and exhibitions. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated. The facility has two cats and a pet therapy team visit monthly. There is community input from Communicare and the RSA. Residents also go out to Salvation Army concerts, cafés, shops and the pub. The art therapy project commenced in 2015 continues, and has expanded to include community involvement and art fairs. There is a wide involvement from all residents. The YPD residents who attend are very enthusiastic and the DT stated they enjoy the project. Residents have an activity assessment completed over the first few weeks following admission that describes the residents' past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly. The residents' committee is elected. Full meetings are held two monthly, but the committee members meet two weekly. The service has exceeded the required standard around the continuing and evolving art therapy programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a	FA	The five long-term care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. Short-term care plans for short-term

comprehensive and timely manner.		needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the long-term residents, and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP/NP and resident/family if they wish to attend. There are three monthly reviews by the GP/NP for all residents. The family member interviewed confirmed that they are informed of any changes to the care plan.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The facility has a current warrant of fitness dated 23 December 2017. The new building has been completed and a certificate for public use has been issued. All shared ensuites had privacy locks. Hot water monitoring has been completed. The medication room is completed and includes secure locking on the entrance door. The previous partial attainments from their partial provisional audit have been addressed.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	An emergency bell system has been installed in the new wing and is fully functional. The previous partial attainment has been addressed. There is a call bell system throughout the whole facility.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	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 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 was sporadic between November 2017 and April 2018, but was consistent prior to and since this time). This data is monitored and evaluated monthly and annually and is provided to Radius head office. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality meetings and staff meetings, and plans and interventions resulting from surveillance create improvements in a way that exceeds the required standard. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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. There were four residents using enablers and four hospital residents with restraints during the audit. Two resident files were reviewed where an enabler was in use. Voluntary consent and an assessment process were completed. The enabler is linked to the resident's care plan and is regularly reviewed. Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Radius has a training plan that covers all required areas over a two-year period and exceeds eight hours annually. A recent intensive ‘catch up’ period has occurred when a corrective action plan was developed around staff training. Staff interviewed indicated they are able to request training on various topics and these are provided where possible. Performance appraisals were not current.	Five of five staff files sampled did not have a current performance appraisal.	Ensure all staff have an annual performance appraisal completed. 90 days
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.	PA Moderate	The respite resident did not have an interim care plan. Care was provided from the documentation in the resident’s daughter’s letter. Four out of five long-term care plans had interventions documented that supported needs and provided detail to guide care. There were six monthly reviews of care plans or more frequently where needs had changed. Multidisciplinary reviews also occurred.	(i) The respite resident had no interim care plan. (ii) The resident who has a port line for dialysis has no documented care of the port line in the care plan.	(i) Ensure respite residents have interim care plans. (ii) Ensure all appropriate care is documented in the care plan.

				60 days

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	An art therapy project commenced in September 2015, with the aim to maintain physical, sensory, cognitive, social/emotional communication for residents of all ages. Resident participation impacted positively on the quality of the lives of those participating. Residents and families expressed satisfaction with the project and the benefits of participation. This project continued in 2016 and 2017.	The DT has extended the art therapy programme to include a Community Art Project. This was organised through the Panmure Business Centre. It has provided an opportunity for the art group to socialise with other artistic people in the community and to view and appreciate different art styles and technique. One YPD resident stated that the art group brings not just great satisfaction, but great joy. In May 2018, the facility held an art fair for residents to exhibit their art. This further promoted a sense of achievement, self-esteem and self-worth. Post art fair, the DT put out a survey to all art therapy participants. The feedback around the Community Art Project and the art fair was overwhelmingly positive. All participants wish for this to continue.

End of the report.