

# Radius Residential Care Limited - Radius Baycare Home and Hospital

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## Introduction

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

The audit has been conducted by 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 Baycare Home and Hospital

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

**Dates of audit:** Start date: 22 July 2021 End date: 23 July 2021

**Proposed changes to current services (if any):** This audit included verifying the service as being appropriate to provide residential disability- physical and intellectual disability care.

**Total beds occupied across all premises included in the audit on the first day of the audit: 45**

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Radius Baycare Home and Hospital is owned and operated by Radius Residential Care Limited. The service provides care for up to 46 residents requiring rest home or hospital level care. On the day of the audit there were 45 residents.

This unannounced surveillance audit was conducted against a subset of the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, general practitioner, staff, and management. This audit also included verifying the service as suitable for providing residential disability- physical and intellectual level care.

The service is managed by a facility manager/registered nurse who has experience in aged care management. The facility manager is supported by a Radius regional manager and a clinical nurse manager who has eight years' experience in aged care nursing.

The relatives, general practitioner and residents interviewed spoke positively about the care and support provided at the service.

Two of two previous audit shortfalls around neurological observations and restraint have been addressed.

This audit identified one shortfall around evidence of discussion of quality data.

## 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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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Residents and family member interviewed verified ongoing involvement with the community. Complaints processes are implemented, and complaints and concerns are actively managed and show improvements as a result of investigations.

## 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.
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Radius Baycare is implementing a quality and risk management system that supports the provision of clinical care. Operational and clinical management is provided by a qualified facility manager who has over 20 years' experience in aged care, and a clinical manager (both registered nurses). The regional manager also supports the team.

A quality programme is documented with data and reports tabled at relevant meetings. Corrective actions are developed and implemented.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## 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.		Standards applicable to this service fully attained.
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans, and reviews residents' needs, outcomes, and goals with the resident and/or family input. Care plans reviewed demonstrated service integration and were evaluated at least six-monthly. InterRAI assessments identify needs with these linked to care plans. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses responsible for administration of medicines complete education and medication competencies. The medicine charts were reviewed at least three-monthly by the general practitioner.

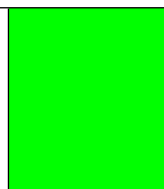
An activities programme is implemented with a range of activities to meet the cognitive, physical, and recreational needs of the residents. The programmes include community visitors and outings, entertainment and activities that meet the individual abilities and preferences for each resident group.

All meals are cooked on-site. Residents' food preferences and dietary requirements are identified at admission. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines.

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.

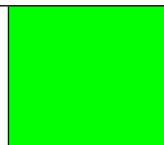


Standards applicable to this service fully attained.

The building holds a current warrant of fitness. Preventative and reactive maintenance occurs. The facility provides safe and easy access to all areas for residents using mobility aids. The outdoor areas are easily accessible and provide seating and shade.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

The service has policies and procedures to ensure that restraint is a last resort. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. At the time of the audit there were two residents with restraints and four residents using enablers. The files for the residents with enablers showed that enabler use is voluntary. Staff receive training in restraint minimisation.

## 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 type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner.

## 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	1	0	0	0
Criteria	0	41	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)
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	<p>Interviews were held during the audit with the clinical and facility managers. Staff were also interviewed including the following: four healthcare assistants [HCA's], two registered nurses, the activities coordinator, and cook. All interviewed confirmed their understanding of the complaints process.</p> <p>The service has a complaints policy that describes the management of the complaints process. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility. There is a complaint register that includes relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings.</p> <p>There have been two complaints made in 2020 and two received in 2021 year to date. Two complaints reviewed included follow-up meetings, letters, investigations of the complaints and resolution completed within the required timeframes as determined by the Health and Disability Commissioner.</p> <p>A complaint was received from the Health and Disability Commission (HDC) in August 2019. The complaint was closed off by the HDC in April 2020. There have not been any other complaints from an external party since the last audit.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Full information is provided on admission for residents and family/whānau. Eight residents (four hospital including one resident identified as a young person with a disability [YPD], and four residents using rest home level of care) interviewed, confirmed they were given an explanation about the services and procedures and that their cultural needs are being met.</p> <p>Management has an open-door policy. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Three family members interviewed (one with family in the rest home, and two with family members in the hospital) confirmed that they were informed of any incident. A review of 15 incident/accidents had documented evidence of family notification or noted if family did not wish to be informed.</p> <p>Interpreter services are available as required if residents or family/whānau have difficulty with written or spoken English. Young people with disabilities did not require specific devices to communicate with.</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 Baycare is part of the Radius Residential Care group. The service currently provides rest home and hospital level care for up to 46 residents including one double room in use as a single. On the day of the audit there were 45 residents i.e. 20 rest home and 25 hospital level residents. This includes six residents requiring hospital (medical) level of care under a YPD contract (one with intellectual disability and five with physical disabilities). One resident at hospital level was funded by ACC and all others were funded under the age-related residential care (ARRC) contract.</p> <p>This audit included verifying the service as being appropriate to provision of care for residents with physical and intellectual disability.</p> <p>The Radius Baycare business plan 2021 to 2022 is linked to the Radius Residential Care group strategies and business plan targets. The mission statement is included in information given to new residents and refers to person centred care. An organisational chart is in place. Quarterly reviews are undertaken to report on achievements towards meeting business goals.</p> <p>The facility manager has been in the role for one year and has two and a half years' experience as a roving manager, are a registered nurse (with a current annual practicing certificate (APC) and have 23 years' experience in aged care. The facility manager is supported by a clinical manager, who has been in the role for seven months with eight years' experience in aged care. The regional manager was supporting the team on the day of audit.</p> <p>The facility manager and clinical manager have maintained more than eight hours of professional development activities related to their roles in the service.</p> <p>There will be no change to the governance or management of the service as a result of verification of the service to have young people with disabilities (YPD) including residents with physical and intellectual disability.</p>

<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>There is an organisational business plan that includes quality goals and risk management plans for Radius Baycare. Quality and risk performance is reported across facility meetings and to the regional manager. The facility manager is responsible for providing oversight of the quality programme.</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 support office, with input from facility staff, reviews the service's policies at 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. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions are evaluated and signed off when completed.</p> <p>There are a range of meetings where data is tabled. This includes a monthly staff meeting, one to three monthly household meetings (dependant on need), monthly infection control and monthly restraint meetings. Head of department meetings are held weekly Triangle of support meetings are held daily. There are also monthly resident meetings with a resident facilitating these. This is a newly implemented process, and the activities coordinator attends to support. Meeting minutes are documented however there is a lack of evidence to confirm that data is discussed.</p> <p>Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The last satisfaction survey for residents was completed in 2021 and this showed an overall satisfaction of 86% (satisfied or very satisfied). The other 14% identified as neutral. Residents scored communication highly with 93% stating that they were satisfied or very satisfied.</p> <p>The service has a health and safety programme in place. There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. Health and safety is discussed at the monthly health and safety meeting and issues are discussed in other relevant meetings e.g. the restraint meetings and household meetings. All new staff complete a health and safety induction including emergency situations, fire safety and safe moving and handling and there is ongoing online training for all staff annually. Hazard identification forms are implemented. There is a current hazard register in place. All contractors complete an induction to the facility.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.</p> <p>There will be no change to the quality or risk management programme as a result of verification of the service to have young people with disabilities (YPD).</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>	FA	<p>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Incidents are included in the Radius key performance indicators (KPI). There is expected to be discussion of incidents/accidents at the monthly staff meetings including actions to minimise recurrence (link 1.2.3.6).</p> <p>A review of 15 incident/accident forms that occurred in 2021 identified that forms were fully completed and include follow-up by a RN. Neurological observations were completed as required and as per policy for unwitnessed falls or suspected injury to the head as sighted in nine incident forms reviewed. The previous shortfall has been addressed. Discussions with the facility manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been section 31 notifications made to notify the Ministry of Health of a registered nurse shortage. These include six-night shifts with an enrolled nurse covering the role and two section 31s raised for the week following the audit as staff have not been able to be secured to cover two shifts. The service has not been able to attract RNs to the area despite extensive advertising. A new registered nurse is scheduled to start work following orientation and this will give the service a full complement of RNs once in place.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files reviewed (one clinical nurse manager, one RN, one enrolled nurse, one HCA, and one activities coordinator) included a recruitment process which included reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals. A register of RN staff and other health practitioner practising certificates is maintained. Registered nurses are supported to maintain their professional competency. The orientation programme provides new staff with relevant information for safe work practice.</p> <p>Staff are required to complete written core competencies during their induction. These competencies are repeated annually. There is an implemented annual education and training plan that exceeds eight hours annually for each staff member. There is an attendance register for each training session and an individual staff member record of training. The facility manager is the only InterRAI trained nurse with four other nurses employed in the service. Registered nurses are supported to maintain their professional competency.</p> <p>HCAs are encouraged to complete CareerForce training. There are three HCAs with level three training completed and six with level four training completed.</p> <p>Staff have had training already around the needs of all residents including YPD. The service will continue to provide training for staff. There will be no change to the training programme as a result of verification of the service to have young people with disabilities (YPD).</p>

<p><b>Standard 1.2.8: Service Provider Availability</b></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. Residents and family members interviewed reported there are sufficient staff numbers. There is a full-time facility manager and a full-time clinical nurse manager who work from Monday to Friday. A registered nurse is rostered on each morning, afternoon, and night shift.</p> <p>The rosters reviewed for the past three months showed the following staff allocated to the following wings:</p> <p>Rest home wing has a total of 21 beds (occupancy of 17 rest home and four hospital residents), and the rest home garden wing has six beds (three rest home and three hospital residents). The morning shift has three HCAs (two long shift and one short shift from 7AM to 1PM). The afternoon shift has one HCA from 3PM to 11PM.</p> <p>Hospital east has 10 beds with 10 hospital residents and hospital west has eight beds and eight hospital residents. The morning shift has five HCAs (all long shift). The afternoon shift has four HCAs (two long shift from 3PM to 11PM, one HCA from 3PM to 9PM and one from 3PM to 10PM). There is an extra enrolled nurse (team leader) rostered on from Monday to Wednesday on morning shift. An enrolled nurse provides additional support (three-day shifts) per week.</p> <p>There are two HCAs rostered onto night shift across all wings.</p> <p>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. On interview staff stated that overall, the staffing levels are satisfactory and that the managers and RNs provide good support. Bureau staff and casual staff have been used to fill gaps in rosters with the facility manager working on the floor to cover shifts if this is required. There will be no change to staffing as a result of verification of the service to have young people with disabilities (YPD) including residents with physical and intellectual disability.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were eleven residents self-administering on the day of audit. Consent forms had been signed and the residents deemed competent to self-administer. The medications (mainly inhalers and GNT spray) were in locked drawers or boxes. Two residents who were self-administering medications had a competency completed to confirm they were able to keep medicines securely and take as prescribed. There were no standing orders. There were no vaccines stored on site.</p> <p>The facility uses a paper-based and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and enrolled nurses administer medications. All staff have up-to-date medication competencies and there has been medication education this year. There are senior medication competent HCAs who check out drugs with RNs. Registered nurses and the enrolled nurse have syringe driver training completed by the hospice. The medication fridge temperature is checked daily. Eye drops</p>

guidelines.		<p>are dated once opened.</p> <p>Staff sign for the administration of medications on medication signing forms. Fourteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed.</p> <p>There will be no change to the medication management system as a result of verification of the service to have young people with disabilities (YPD).</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>	FA	<p>The service has three cooks who cover Monday to Sunday and there is a kitchenhand on each day. All kitchen staff 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 served in each area from 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. 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 the Radius dietitian. All resident/families interviewed were satisfied with the meals.</p> <p>The food control plan has been verified 8 January 2021 with an expiry date documented as 8 January 2022.</p> <p>Kitchen staff and registered nurses already ask for individual input into their nutritional needs and this continues to be put in place for residents identified as YPD. There will be no change to food services as a result of verification of the service to have young people with disabilities (YPD).</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>	FA	<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. There is documented evidence of care plans being updated as residents' needs changed.</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations were completed when there is an unwitnessed fall of a head injury.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and wound evaluation forms are documented electronically. Wound monitoring occurs as planned. There are currently 13 wounds being treated. These included one basal cell</p>

		<p>carcinoma (waiting for surgery), one identified as cradle cap, on pressure injury stage one with a protective dressing in place, one resident with poor circulation with some suppurating areas, one diabetic ulcer, four chronic lesions, one skin tear, one surgical wound, and two with cellulitis.</p> <p>Electronic monitoring forms are in use as applicable such as weight, vital signs, and pressure risk. 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>	FA	<p>There is one activities coordinator who works thirty hours a week. They have been in the role for six years. On the days of audit residents were observed interacting with pre-schoolers who were visiting, doing Tai Chi, and having a birthday morning tea.</p> <p>There is a weekly programme in large print on noticeboards in all areas. 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.</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 a weekly interdenominational church service and Catholic communion on a weekly basis.</p> <p>There are van outings at least twice weekly. Special events like birthdays, Easter, Mothers' Day, and Anzac Day, Matariki, Diwali and the Melbourne Cup are celebrated. There are special activities with a fishing trip planned for the male residents. This follows a mother and daughter celebration held just prior to the audit. Matariki was celebrated this year.</p> <p>There is community input from the local preschools, schools, and other community groups. One project viewed showed paintings completed by preschool children with these used as the covers of picture diaries (one for each resident) that showed activities each had been engaged in. These were particularly well used during Covid 19 pandemic for family to see what the resident had been engaged in. A tai chi instructor comes to the service once a week and a son of a resident teaches chair dancing for older people on a regular basis.</p> <p>The six YPD residents are all in the hospital and are physically impaired. The activities coordinator ensures that they maintain community links with outings to shops, cafes, and movies as much as they can.</p> <p>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 comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly and the activities coordinator is endeavouring to complete these at the same time as the review of the long-term care plan. The activities coordinator ensures that activities are meaningful to the residents and that residents are able to maintain past skills and hobbies if able.</p>

		Residents and relatives interviewed were very happy with the activity programme.
<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 new admission, 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. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The activities coordinator is still working to ensure these are completed at the same time as the long-term care plan. The multidisciplinary review involves the RN, GP, and resident/family if they wish to attend. 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 31 May 2022. The maintenance person works five days a week. There is a gardener who works sixteen hours a week. Contracted plumbers and electricians are available when required.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The corridors are wide, have safety rails 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 and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>HCA's interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents. This also includes adequate equipment and a safe environment for residents identified as YPD.</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>The surveillance programme is organised and promoted centrally from support office. Effective monitoring is the responsibility of the infection control coordinator (facility manager/RN). An individual infection report form is completed for each infection. Data is logged into an electronic system, which gives a monthly infection summary. This summary is then discussed at the RN meeting and monthly staff meetings (link 1.2.3.6).</p> <p>The overall effectiveness of the surveillance program is evaluated annually by the infection control committee. The IPC programme is incorporated into the internal audit programme. Infection rates are benchmarked across the organisation with data tabled at relevant meetings.</p> <p>There have been no outbreaks since the last audit.</p> <p>The service has prepared at least two weeks of personal protective equipment including gowns, gloves, and masks. Staff have completed training on use of PPE, cough etiquette and hand hygiene. Residents are provided with</p>



		training and oversight of standard precautions with this occurring during resident meetings and as required.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. The facility is working to become restraint free with the number of restraints having decreased from 12 restraints a year ago to two bedrails identified as restraints currently in use. There were four enablers (bedrails) in place at the time of the audit. Documentation is available in relation to the restraints and enabler use; the previous shortfall has been addressed. Staff training has been provided around restraint minimisation in 2021 with a competency completed annually by all staff.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Monitoring is documented on a specific restraint monitoring form and reflects the actual times monitoring occurred, evidenced in two resident files where restraint was being used. Care plans include interventions to manage the risks associated with restraint as sighted in the two files reviewed where restraint was in use. The shortfall relating to documentation of interventions to manage the risk associated with the use of bed rails (restraint) has been addressed.</p>

## 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 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	The service collects and collates quality and risk data. Meeting minutes reviewed for staff and health and safety meetings for example, do not always reflect discussion of the data.	Quality and risk data (e.g. falls, skin tears, and results of audits) is not being discussed at relevant meetings with evidence of improvements made as a result of the discussions.	Ensure data is discussed at relevant meetings with meeting minutes showing evidence of this.  180 days

## 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.