# Radius Residential Care Limited - Radius Hawthorne

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Radius Residential Care Limited

**Premises audited:** Radius Hawthorne

**Services audited:** Hospital services - Psychogeriatric services; 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: 30 January 2019 End date: 31 January 2019

**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:** 81

# 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 |
|  | 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 Hawthorne is part of the Radius Residential Care Group. Hawthorne cares for up to 94 residents requiring hospital (medical and geriatric), psychogeriatric, residential disability - physical and rest home level care across four units. On the day of the audit there were 81 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and general practitioner.

The experienced facility manager has been in the role for one year and has previous experience with Radius as a manager in another facility. She is supported by a clinical manager, and a roving clinical support coordinator (both new to the role), and the Radius regional manager. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

The service has addressed four of seven findings from the previous audit around staffing cover, aspects of medication, and medication competencies and evaluations. Further improvements are required in relation to: staff education; quality reporting; and timeliness of documentation.

This audit has identified improvements required around EPOAs, orientation, appraisals, progress notes, behaviour triggers, medication management and fridge temperatures.

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

Discussions with families identified that they are fully informed of changes in health status. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The facility manager is qualified and experienced for the role. The quality and risk management programme includes service philosophy, goals and a quality planner. Meetings are held to discuss quality and risk management processes. Residents meetings are held regularly, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An education and training programme has been implemented with a current plan in place. There is a roster that provides sufficient and appropriate coverage for the effective 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Initial assessments and risk assessment tools are completed by the registered nurses on admission. Registered nurses are responsible for care plan development with input from residents and family and care plans document interventions for all identified needs. Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme. There are medication policies which align with guidelines. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Snacks are available 24 hours a 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. |

A current building warrant of fitness is posted in a visible location. There is a preventative and reactive maintenance schedule in place. Outdoor areas are well maintained and easily accessible. Indoor areas are light and spacious with room for residents to move around freely with mobility aids.

## 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. |

Hawthorne has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were five residents with restraint and three residents with an enabler.

## Infection prevention and control

|  |  |  |
| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

Radius Hawthorne has an infection control programme that complies with current best practice. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

## 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 | 10 | 0 | 3 | 4 | 0 | 0 |
| **Criteria** | 0 | 32 | 0 | 6 | 4 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low | Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their EPOA. Advanced directives are signed for separately. There was evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives. Signed enduring power of attorney documentation was not evident in all files in the psychogeriatric files. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | A complaints policy and procedure is in place. The complaints procedure is provided to residents and their family within the information pack at entry. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint’s forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception.  Four complaints were received in 2017, five complaints for 2018 and two complaints for 2019 year to date. Two complaints from 2018 were received via the Health and Disability Commission. The service has responded to both complaints in requested timeframes and investigations are ongoing. Where the service identified opportunities to improve, this was communicated at staff meetings and education occurred. All complaint responses were completed within the contractual timeframes in accordance with guidelines set forth by the Health and Disability Commissioner. A review of the complaints register evidences that the appropriate actions have been taken in the management and processing of these complaints. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures are in place to guide staff on the process around open disclosure. The facility manager and clinical manager confirmed family are kept informed. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. The most recent family/resident survey achieved 70% for communication. Bi-monthly resident and family meetings encourage open discussion around the services provided (meeting minutes sighted).  A sample of twelve incident reports reviewed, and associated resident files evidenced recording of family notification. Five relatives interviewed (three psychogeriatric and two hospital) confirmed they are notified of any changes in their family member’s health status. The facility manager, clinical manager, clinical support manager, seven registered nurses (four who work in psychogeriatric and three from the hospital/rest home) and six healthcare assistants (three who work in the hospital/rest home and three from the psychogeriatric unit) were able to identify the processes that are in place to support family being kept informed. The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Hawthorne is part of the Radius Residential Care group. The facility is certified to provide hospital, rest home, psychogeriatric and residential physical disability care for up to 94 residents (47 in the 2 psychogeriatric units and 47 including 10 dual purpose beds in the hospital units).  Eighty-one residents were living at the facility during this audit – thirty-one at hospital level, seven at rest home level and forty-three at psychogeriatric level. This included four residents on younger persons with disabilities contracts, four long-term chronic health conditions contract, two respite residents and one on an ACC funded contract, all receiving hospital level care.  Radius has an overall business/strategic plan which describes the vision, values and objectives of Radius Hawthorne. Business plan targets for 2018 to 2019 identify goals which are linked to the business plan. Progress towards goals is measured and reported monthly. The current manager identified a number of issues and in conjunction with the regional manager and roving clinical coordinator, developed a comprehensive corrective action plan to address these issues.  The facility manager (FM), an enrolled nurse, is well trained and experienced in health management and has been in the role for one year. Prior to commencing at Hawthorne, the FM had been in a similar management role with Radius for three years. The clinical manager (CM), has been at Hawthorne for three weeks and has been involved in aged care for ten years including two years as a clinical manager. She is supported by the Radius roving clinical support coordinator.  The facility manager has maintained at least eight hours of professional development activities related to managing an aged care facility. |
| 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. | PA Moderate | There is an organisational business plan that includes quality goals and risk management plans for Radius Hawthorne. Interviews with three managers (facility manager, clinical manager and regional manager) and staff (six healthcare assistants, seven registered nurses, one kitchen manager, one diversional therapist and one maintenance officer) confirmed that quality data, including trends is routinely discussed at monthly staff meetings.  Discussions with the managers, and staff reflected staff involvement in quality and risk management processes. There are clear guidelines and templates for reporting. Radius Hawthorne has implemented established processes to collect, analyse and evaluate data, which are utilised for service improvements. Quality data including monthly accident incidents, infection and internal audits are conducted and corrective action plans are developed and implemented for these when shortfalls are identified. Corrective actions are evaluated and signed off when completed. Results are communicated to staff in meetings and on staff noticeboards. This is an improvement from the previous audit. Annual resident satisfaction and family satisfaction surveys are conducted, and results are correlated. However, analysis, trending and discussion has not occurred in 2018.  The service's policies are reviewed at national level by the clinical manager group with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals.  The service has a health and safety management system that meets current legislative requirements. 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 health and safety team identify and report hazards on hazard forms which are then eliminated or minimised and added to the regularly reviewed hazard register. Contractors undergo a health and safety induction. Health and safety is included as part of the staff orientation programme (link 1.2.7.5).  Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. |
| 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 accidents and incidents reporting policy. Accidents and near misses are investigated by the clinical manager and analysis of incident trends occurs. Incidents are included in the Radius key performance indicators (KPIs). There is a discussion of incidents/accidents at monthly staff meetings including trends and actions to minimise recurrence. Clinical follow up of residents is conducted by a registered nurse as confirmed on 12 incident reports sampled. Discussions with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Senior management were aware of the requirement to notify relevant authorities in relation to essential notifications. One section 31 incident notification form was completed in the past 12 months. The notification related to an unstageable pressure injury in 2018. |
| 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 Moderate | There are human resource management policies in place which includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Seven staff files were reviewed (one clinical manager, two staff RN’s, one diversional therapist and three healthcare assistants) and evidenced that reference checks are completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. However, not all staff have completed orientations on file. An annual in-service programme is provided with all compulsory sessions provided either annually or biannually. A new process recently implemented has demonstrated a marked increase in attendance rates. However, not all staff attended required education over the previous two years. The previous shortfall continues to require addressing.  There are 25 caregivers who work across the PG units. Twenty-four have completed the dementia NZQA standards. The remaining employee (who has not worked in the PG unit for 18 months) has enrolled and nearly completed dementia training. The activities coordinator has completed dementia training. This is an improvement on the previous audit.  There are seven interRAI trained staff. Competencies are completed for Nikki T, manual handling, hand hygiene, and medication. |
| 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 Radius policy is in place for determining staffing levels and skills mix for safe service delivery. Sufficient staff are rostered on to manage the care requirements of the residents. The facility manager (enrolled nurse) and clinical manager, work full-time and jointly cover on-call responsibilities. Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations within contractual timeframes. Interviews with residents and family members identify that staffing is adequate to meet the needs of residents.  The service is divided into four units with staffing as follows:  Brunner (psychogeriatric unit): currently 18 of a potential 20 residents. There is a registered nurse on duty 24 hours per day. On morning shifts, two healthcare assistants work a full shift and two a short shift. On afternoon shifts, two healthcare assistants work a full shift and two work a short shift. On night shift, there is one healthcare assistant.  Victoria (psychogeriatric unit): currently 24 of a potential 27 residents. There is a registered nurse on duty 24 hours per day. On morning shifts, two healthcare assistants work a full shift and three a short shift. On afternoon shifts, two healthcare assistants work a full shift and two work a short shift. On night shift, there is one healthcare assistant.  A qualified diversional therapist and two activities staff provide a programme weekdays and care staff provide activities in the psychogeriatric wings during the weekend.  Sumner and Wanaka/Tekapo share registered staff on night shift. There is a registered staff member on duty on each morning and afternoon shift and one RN based in Sumner but supporting Wanaka/Tekapo overnight. Sumner and Wanaka/Tekapo are adjacent to each other.  Sumner (hospital/rest home unit): currently 24 of a potential 27 residents (1 rest home and 23 hospital). There is a registered nurse on duty 24 hours per day. On morning shift, two healthcare assistants work a full shift and two a short shift. On afternoon shift, two healthcare assistants work a full shift and two work a short shift. On night shift, there is one healthcare assistant.  Wanaka/Tekapo (hospital/rest home unit): currently 14 of a potential 20 residents (6 rest home and 8 hospital. Two healthcare assistants work a full morning shift and one a short shift and one works a full afternoon and two a short shift. There are two healthcare assistants on duty overnight. Staff from Sumner support Wanaka/Tekapo staff if required.  Rosters sighted evidenced at least one registered nurse had been on duty at all times in both the hospital and psychogeriatric wings. This is an improvement on the previous audit. |
| 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. | PA Moderate | Twelve medication charts were reviewed (six hospital level, four PG and two rest home level). Medications are checked against the doctor's medication profile on arrival from the pharmacy by an RN. Any errors by the pharmacy are reported back to the pharmacy.  Nine of twelve (three residents had been at the service less than three months) medication charts reviewed, identified that the GP had reviewed the resident three-monthly, allergies are documented, and the medication chart was signed. The previous finding around documentation of allergies has been addressed.  All medication charts indicate medication is being administered as prescribed. All medication charts document the indication for giving the ‘as required’ medication, however not all short-term medications have been discontinued on the medication chart by the GP.  Two registered nurses were observed safely and correctly administering medications on the medication rounds sighted. All staff who administer medications have current medication competencies on file. RNs complete other competencies for syringe drivers, insulin administration and dialysis prior to administration. The previous finding has been addressed.  There was one fully self-medicating resident, and two residents who self-administered ‘as required’ inhalers on the day of the audit. All have medication competencies, which are reviewed three-monthly and medications are stored safely in the residents’ room.  All expired medications are returned to the pharmacy, and eye drops, and creams were dated on opening. However, the medication trolley and keys were found unattended, and unlocked. |
| 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. | PA Low | The service has a food control plan in place which expires 30 March 2019. The kitchen is a commercial kitchen operated by a contracted company and also provides meals for other residential services. The kitchen and the equipment are well maintained. The service employs sufficient kitchen staff to provide meal services over seven days a week. There is a rotating four-weekly menu in place that is designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed.  Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented.  The residents interviewed spoke positively about meals provided and they all stated that they are asked by staff about their food preferences.  The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires. All food is stored and handled safely. Food temperatures are recorded. A cleaning schedule has been implemented. Fridge and freezer temperatures throughout the facility have not always been checked and recorded consistently.  Kitchen staff have been trained in safe food handling.  The service caters for the needs of younger residents and those identified as weight loss or risk of weight loss. Alternatives are available and there are nutritious snacks available in all of the units 24 hours a day. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | The care being provided at Radius Hawthorne is consistent with the needs of residents as demonstrated on the overview of the care plans, and discussions with family, residents, staff and management.  Short-term care plans, turning charts, food and fluid records and behaviour monitoring charts were evident. However, neither the behaviour assessments or the behaviour care plan document possible triggers of behaviours.  Dressing supplies are available. There was one resident with a stage II pressure injury on the day of the audit. A wound assessment, plan and evaluation of the pressure injury documents healing progression. A sample of wounds throughout each unit shows each wound has an assessment, plan and evaluation which shows wound progression or deterioration. The wound care specialist has been involved with a resident with chronic wounds. Staff interviewed feel they have a good supply of equipment to provide care.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.  Registered nurses interviewed were able to describe access to specialist services if required. |
| 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. | FA | There is one diversional therapist and two activity officers who work in the facility across all service levels over five days. All recreation/activities assessments and reviews are completed within expected timeframes. Progress notes are maintained in the integrated electronic files and demonstrate each residents level of participation.  On the day of audit, residents from the hospital and PG wings were observed being actively involved with a variety of activities in the main lounge and throughout the facility. Residents have a comprehensive assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family.  Activities are age appropriate (including to meet the need of younger residents) and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Some of the residents and staff along with volunteers, deliver meals on wheels to the community. There are children groups which visit the facility, and a variety of religious denominations visit on a weekly basis. Special anniversaries and days are celebrated.  Healthcare assistants provide activities and stimulation in the PG wings when activities staff are not available. There is a 24-hour activity care plan to assist staff to provide activities in the PG and hospital wings in the evenings and weekends, and there are a variety of games and activities available.  All residents and family members interviewed stated that activities are appropriate and varied and spoke positively about the programme, especially the combined group activities. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Initial care plans are evaluated by the registered nurses within three weeks of admission in four of six files. Three of the long-term files sampled had an interRAI assessment completed within 21 days of admission (link 1.3.3.3). The interRAI ongoing assessments and the long-term care plan were evaluated at least six-monthly or earlier if there is a change in health status. There was at least a three-monthly review by the GP. In files sampled, all changes in health status were documented and followed up. Care plan reviews are signed by an RN.  Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.  Where progress is different from expected, the service responds by initiating changes to the care plan. There is a note on the electronic template to indicate what the changes have been made to the care plan, and progress towards achieving goals, or goals changing as condition changes. The previous finding has been addressed. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry date 1 January 2020). Hot water temperatures are checked and recorded on a monthly basis and are within range.  There is a maintenance log in the electronic system for staff to record breakages, which is checked daily. There is a preventative maintenance schedule which is maintained. The indoor areas are light and spacious with room for residents to manoeuvre mobility aids and wheelchairs. The outside areas are easily accessible, the grounds are well maintained by the gardener with seating and shade provided. Residents were observed moving around the building with mobility aids and wheelchairs. |
| 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 and monitoring is an integral part of the infection control programme and is described in policy. A registered nurse is the designated infection control coordinator. The surveillance of infection data assists in evaluating compliance with infection control practices at facility and Radius wide. Infections and suspected infections are collated monthly, analysed and the data is reported at the facility meetings. The service submits data monthly to Radius head office where benchmarking is completed. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked.  There is a regional restraint group at the organisational level and there is a designated restraint coordinator at the facility. Restraint use is reviewed at monthly clinical meetings.  There are three hospital level residents with enablers in the form of bedsides and lap belts. Review of files for residents with enablers and interviews with two residents confirmed that enabler use is voluntary and the least restrictive option possible.  There were five residents with restraints at the time of the audit (all PG). The implemented policy around the management of disturbed behaviours reduces the need for restraint. |

# 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 1.1.10.4  The service is able to demonstrate that written consent is obtained where required. | PA Low | Admission agreements are in place for all resident files sampled. Relatives interviewed confirm they are involved in care planning and are informed of any changes to the resident’s health condition and GP reviews/ updates. However, not all EPOAs are activated on file in the psychogeriatric wings. | Six psychogeriatric files were reviewed (four for EPOA only). Four files did not have an activated EPOA on file, however one of these files did have documentation of assessment and court order for guardianship. | Ensure all EPOAs have been activated and are on file for all dementia residents on admission.  90 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 Moderate | Quality improvement data on infections, adverse events, complaints and internal audits is collected, analysed, trended and discussed at staff meetings. This is an improvement on previous audit. Surveys are distributed annually and correlated, however, there is no evidence of further evaluation or communication. | Survey results for 2018 have not been analysed. Results have not been evaluated or shared with staff, residents or families. | Ensure survey results are analysed and results communicated to staff and where appropriate with consumers  90 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Radius policies include annual staff reviews which provide assurance that staff are continuing to meet documented requirements of their role. Not all employees evidenced appraisals within the previous year. Orientation completion and understanding is followed up at a three-month appraisal. However not all recent staff files evidence this has occurred. | (i)Two of four long-term staff who have been employed longer than eighteen months did not evidence appraisals had been completed. (ii) Three of seven staff who have been employed over six months have not had a three-month appraisal completed. | (i)Ensure all staff have annual reviews completed. (ii) Ensure all staff have three-month appraisals completed  180 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | A comprehensive role specific orientation programme is implemented for each new employee to be completed within three months of commencing employment. However, not all staff have completed orientations on file. | Two registered nurses that have been at the facility for over six months do not have completed orientations on file. | Ensure all staff have completed orientations on file.  90 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 Moderate | Late 2018, it was identified that not all education sessions had been held as scheduled. A corrective action plan was implemented where all required sessions have been rescheduled. Recent attendance at a combined session in January has increased to 80%, however, attendance at previous mandatory sessions had been poor. Radius identified this issue and a corrective action plan was developed and implemented. Training sessions are now planned as half or whole day events with sessions being provided more than once on different days and at different times of day to ensure high attendance. All required training has either been provided or is scheduled. All staff working in the psychogeriatric units have completed (or nearly completed) the required dementia standards. There is education and training for staff that covers meeting the needs of younger persons with disability (eg Sexuality and Intimacy, privacy). | Staff attendance at some required trainings is less than 50% (continence, skin care & PI prevention, pain management, H & S and emergency training, dementia, delirium and challenging behaviour). | Ensure staff attend mandatory training sessions.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The service uses blister packed medication, and these are checked on arrival by a registered nurse and any pharmacy errors are recorded and fed back to the supplying pharmacy. Medications are stored in locked cupboards in a locked room, however the medication was locked for with the nurse. There were no expired medications on-site.  Staff sign for administration of medication on medication sheets. The medication folders include a list of specimen signatures and competencies. All ‘as required’ medication charted includes an indication for use. Not all medication charts document when short-term medications have been discontinued. | i)Two resident’s medication charts documented short-term antibiotics (total of eight entries) prescribed for a week at a time (which are no longer given) that have not been discontinued on the medicine chart by the GP.  ii) The medication trolley and keys were found unattended in the nurse’s station with the door open. | i)Ensure that medication charts are reviewed, and short-term medications have been discontinued by the GP on completion of the course.  ii) Always ensure the medication trolley is locked when unattended, and the keys are in possession of the RN at all times.  30 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | All fridge and freezer temperatures in the kitchen have been checked according to legislation, however not all of the fridge and freezer temperatures that store food for the residents in the facility have been checked accordingly. All food in the fridges in the wings is covered and dated and discarded within 24 hours if not used. There is nutritional snacks available in all wings for residents at all times. | The fridge/ freezer temperatures have not been consistently recorded in the Sumner wing. | Ensure the temperature of the fridge/ freezer is checked and recorded on a daily basis.  90 days |
| Criterion 1.3.3.3  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. | PA Moderate | Initial assessments are completed for each resident on admission to the service. Interim care plans are in place for the first three weeks until the interRAI assessment and long-term care plans are developed. Not all interRAI assessments are completed on time at admission. This continues to be an area requiring improvement. | One rest home file, and one psychogeriatric file sampled did not have an interRAI assessment or long-term care plan completed within 21 days of admission | Ensure all assessments and care plans are completed within 21 days of admission.  90 days |
| Criterion 1.3.3.4  The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | Progress notes are completed on the electronic file for all residents at the end of each shift. Progress notes completed by the HCAs describe cares given, food and fluid intake, position changes and comment on resident’s mood throughout each shift. RN notes are not always documented on a daily basis | (i)Progress notes of one hospital file identified no RN progress notes documented for four days.  (ii)RN progress note in one PG resident file does not describe the details of the residents “unsettled behaviour” or diversion/ de-escalation techniques used prior to administering antipsychotic drugs. There are no details of the resident’s movements and mood throughout the day. | Ensure all registered nurses notes are documented on time and provide details of resident’s condition and episodes of challenging behaviours.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Staff interviewed were aware of residents’ specific needs in the psychogeriatric units. They could identify behaviours and de-escalation techniques used, these are evident in the care plan interventions. However, possible triggers are not identified in either the care plans or the behaviour charts on the electronic file. | In two psychogeriatric files reviewed (one from each unit), there were no possible triggers either environmental or sensory in the care plans or behaviour charts reviewed. | Ensure triggers are identified and included in the care plans and the behaviour charts to alert staff to avoid potential episodes of challenging behaviours.  90 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.

|  |
| --- |
| No data to display |

End of the report.