Radius Residential Care Limited - Radius Fulton Care Centre

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 Fulton Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 16 December 2021 End date: 17 December 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 90

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 Fulton Care is owned and operated by Radius Residential Care Limited. The service provides rest home, dementia, and hospital (geriatric and medical) levels of care for up to 93 residents. On the day of the audit there were 90 residents.

This surveillance audit was conducted against the relevant Health and Disability Services standards and the contract with the district health board. The audit process included a review of quality systems, the review of residents' and staff files, observations and interviews with residents, relatives, staff, management, and the general practitioner.

The service is managed by an experienced facility manager who has been in the role for the past 19 years. The nurse manager (RN) has been in the role for seven years, having previously been a nurse manager at another Radius facility. They are supported by the Radius operations manager, regional manager, a clinical nurse manager, and a team of registered nurses. Residents, relatives, and the GP interviewed spoke positively about the service.

There were no shortfalls identified at the previous audit.

This audit identified that the service continues to meet the health and disability standards and has carried on with the continuous improvement around falls management.

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.

Discussions with residents and relatives confirmed that residents, and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

A facility manager and nurse manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. The quality and risk management programmes are embedded in practice. Results are shared with staff. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

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

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

Continuum of service delivery

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.

Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files included medical notes by the contracted general practitioners and visiting allied health professionals.

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

The diversional therapist implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links within Covid-19 restrictions. There are regular entertainers, outings, and celebrations.

All meals are cooked on site by an external catering company. A current food control plan is in place, and the menu has been approved by a dietitian. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were overall satisfied with the food service. Nutritious 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.

Radius Fulton Care Centre has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Medical equipment and electrical appliances have been tested, tagged, and calibrated (where applicable). Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior areas are well maintained with safe paving, outdoor shaded seating, and gardens.

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. The service has appropriate procedures for the safe assessment and review of restraint and enabler use. A register is maintained. There were three (hospital level) residents using enablers and three (hospital level) residents using restraints during the audit. Assessment and evaluation processes are being implemented.

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 facility has responded promptly and appropriately to the Covid-19 pandemic; policies, procedures and the pandemic plan have been updated to include Covid-19. Resource information is easily accessible for registered nurses if lockdown levels change after hours. Adequate supplies of personal protective equipment were sighted during the audit. There has been one outbreak since the previous audit, which was managed and reported appropriately.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	1	40	0	0	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	The service has a complaints policy that describes the management of the complaints process. Complaints forms and a suggestion box are available at the entrance to the facility. Information about complaints is provided on admission. Residents and relatives are also provided with a brochure on the health and disability advocacy service. Interviews with four residents (two rest home and two hospital) and relatives confirmed their understanding of the complaints process with examples provided. A health and disability advocate attends residents' meetings six-monthly. Staff interviewed were able to describe the process of reporting complaints. There is a complaint register that includes complaints received, dates and actions taken. The facility manager signs off each complaint when it is closed. Only one complaint has been lodged in 2021 (year-to-date). This complaint has been managed in a timely manner, meeting requirements determined by HDC and is documented as resolved. Two complaints, lodged with HDC, remain open. One HDC complaint, lodged in 2019 around resident cares, reflects the implementation of corrective actions including ensuring the RNs are confident and their competency is assessed following a three-month period of orientation. The facility remains focussed on ongoing clinical education with a robust schedule of in-services and impromptu training (toolbox talks) sighted. A second complaint, lodged with HDC in 2020, is in relation to the 2020 period of Covid lockdown. This complaint also remains open. No corrective actions have been required as noted at the time of the audit. The complaints process is linked to the quality and risk management system. There is evidence of lodged complaints being discussed in the staff meetings.

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 record family notification when entering an incident into the electronic system. All 15 accidents/incidents reviewed met this requirement. Interviews with five family members (two dementia, three hospital) commented that they are notified following an incident or change of health status of their family member. Family/resident meetings provide a venue where issues can be addressed. There is an interpreter policy in place and contact details of interpreters were available. Staff and family are used as interpreters in the first instance. There were no residents at the care facility at the time of the audit who were unable to speak/understand English.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Fulton Care Centre is part of the Radius Residential Care group. The service provides rest home, dementia, and hospital (geriatric and medical) levels of care. Over this two-day surveillance audit, there were 90 residents living at the facility with 93 beds available. There are 18 dual-purpose beds. There were 23 rest home level residents, 17 dementia level residents in the 19-bed secure dementia ward, and 50 hospital level residents. Four residents were on respite (three hospital, one rest home) with one respite funded by ACC, and one respite funded by Accessibility. One (hospital level) resident was funded by ACC and one (hospital level) resident was on a long-term support - chronic health conditions (LTS-CHC) contract. All remaining residents were on an age-related residential care (ARRC) contract. The facility manager has been in the role for the past 19 years. The nurse manager (RN) has been in the role for seven years, having previously been a nurse manager at another Radius facility. The facility manager reports to a regional manager who was available during the audit. The managers have completed in excess of eight hours of professional development in the past 12 months. Radius as an organisation has a philosophy of care, which includes a mission statement. Radius has an overall strategic plan and Fulton Care has a facility business plan (April 2021 to March 2022) that links to the strategic plan. Annual business plan targets are established and progress towards meeting the goals are reviewed quarterly.
Standard 1.2.3: Quality And Risk Management Systems The organisation has	FA	An established quality and risk management system is embedded into practice. Quality and risk performance are reported in staff meetings and to the regional manager. Discussions with the managers (facility manager, nurse manager, regional manager) and staff (four healthcare assistants (HCAs) who work in the rest home, hospital, and dementia wings, three registered nurses including one clinical team leader, one maintenance, one diversional therapist, and one kitchen manager) reflected the staffs' involvement in quality and risk management processes.

an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		Annual resident/relative surveys were last completed in June 2021 and a food satisfaction survey was completed in August 2021. Results have been collated and discussed with staff and residents, evidenced in the meeting minutes. No corrective action plans were identified as a result of the surveys. Overall, residents and families are satisfied or very satisfied with the services received with a 90% satisfaction rate. The service has policies and procedures and associated implementation systems, adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level every two years. Clinical guidelines are in place to assist care staff. The quality monitoring programme is designed to monitor contractual, and standards compliance and the quality of services delivered in the facility and across the organisation. Processes are embedded to collect, analyse, and evaluate data, which is utilised for service improvements. There are guidelines and templates for reporting. Key performance indicators (KPIs) are established. Where results fail to meet what is expected, a corrective action plan is implemented. These are tracked on a corrective action register. Corrective actions are evaluated and signed off when completed. Results are communicated to staff in meetings and on staff noticeboards. Health and safety policies are implemented and monitored by the health and safety committee. Health and safety annual objectives are developed and regularly reviewed. Two health and safety officers were interviewed (maintenance and reception staff). Risk management, hazard control and emergency policies and procedures are being implemented. The site-specific hazard register is reviewed six-monthly. Staff training begins during their induction to the service and continues through in-services and monthly staff meetings. An induction programme is also being implemented for external contractors. A range of strategies to reduce falls reflect evidence of ongoing successful results. This rating of continuous improvement remains in place.
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	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 electronically for each incident/accident with action(s) noted and any follow-up action(s) required. A review of 15 accident/incident forms (witnessed and unwitnessed falls, pressure injury, medication errors, skin tears) identified that the electronic forms were fully completed and included follow-up by a registered nurse and sign off by the nurse manager. Accident/incident forms are completed when a pressure injury is identified. Neurological observations were completed for any suspected injury to the head or unwitnessed fall. The facility manager was able to identify situations that would be reported to statutory authorities. There was evidence of Section 31 reports completed for pressure injures and RN staffing issues. A Section 31 was also completed for an unexpected death although a coroner’s inquest was not required. There was one infectious

their family/whānau of choice in an open manner.		outbreak in 2021 with the Public Health authorities and DHB notified.
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.	FA	Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one clinical team leader/RN, two staff RNs, three HCAs) included a recruitment process (interview process, reference checking, police check), signed employment contracts and job descriptions and completed orientation programmes. 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 and includes a system for determining staff competency across a range of topics (e.g., falls prevention, communication, restraint, basic cares/observations, aging process, infection control, informed consent). There is an implemented annual education and training plan that meets contractual requirements. In-service education is complimented with impromptu (toolbox) talks and competency assessments. There is an attendance register for each training session and an individual staff member record of training. Performance appraisals were up to date in the staff files reviewed of staff who had been employed for one year or longer. Registered nurses are supported to maintain their professional competency. Twelve RNs and one EN are employed, and six RNs have completed their interRAI training. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies. There are 37 HCAs: 12 have a level 2 qualification, 11 hold a level 3 qualification and 14 hold a level 4 qualification. There are 11 HCAs who work in the dementia unit. They have all completed their required dementia qualification.
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 across four wings: Both the facility manager and nurse manager are RNs with current practising certificates work Monday – Friday. Registered nursing staff are rostered across all three shifts with a minimum of one RN (night shift) seven days a week. Use of agency staff is used for healthcare assistant vacancies that are unable to be filled. The clinical nurse manager and facility manager share on call responsibilities The facility manager (non-clinical) and nurse manager are full-time employees who are rostered Monday – Friday. Two clinical nurse leaders/RNs cover a total of six days a week (Monday – Saturday). At the time of the audit there was a full complement of RNs. Three RNs are rostered on the AM shift (minimum), two RNs on the PM shift and one RN on the night shift. Glenedin wing: (dementia wing with 17 residents): One RN covers the AM shift (in addition to six hospital level beds in the McKenzie wing). The AM shift is staffed with two long (eight hour) shift HCAs, the PM shift is staffed with one long and two short shift HCAs and the night shift is staffed with one long shift HCA.

		McKenzie wing (11 hospital and 16 rest home residents): In addition to the RN from the dementia wing, one RN covers the AM shift with RN oversight on the PM and night shifts from the other wings. The AM shift is staffed with two long shift HCAs and one short shift, the PM shift is staffed with two long shift and the night shift is staffed with one HCA. Brookside wing (18 hospital and 5 rest home residents): One RN covers the AM and PM shifts and provides RN services to the entire facility during the night shift. Two long shift and two short shift HCAs cover the AM shifts and the PM shifts. One HCA covers the night shift. Lisburn wing (21 hospital and 2 rest home residents): One RN covers the AM and PM shifts. Two long shift and two short shift HCAs are staffed on the AM shift and two long and two short shift HCAs are staffed on the PM shift. One HCA covers the night shift. An additional HCA works as a floater for a total of five HCAs on the night shift. The facility manager reported that staff turnover has been higher than expected, especially for registered nurses, but has now stabilised. Staff were observed attending to call bells in a timely manner. Residents and family interviewed reported there were 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	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Registered nurses and medication competent senior healthcare assistants are responsible for the administration of medications and they complete an annual medication competency and attend medication education annually. Medication fridge temperatures and medication room temperatures are recorded and within expected ranges. The RN on duty reconciles the delivery and documents this on the signing sheet. Medical practitioners write medication charts correctly and there was evidence of one to three monthly reviews by the GP. Medication prescribed is signed as administered on the pharmacy generated singing chart. There was one rest home resident self-medicating on the day of audit. Competencies were in place and reviewed by the GP three monthly. Standing orders are not used. All 12 medication records reviewed (four each service level) paper-based medication charts reviewed had photo identification and allergy status identified. Staff were observed to be safely administering medications. Registered nurses and healthcare assistants interviewed could describe their role regarding medicine administration.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's	FA	All meals at Radius Fulton are prepared and cooked on site by a contracted food service company. The food service company operates the business from the commercial kitchen and provides meal services to several other aged care services and community colleges. A food control plan is in place expiring 31 March 2022. All fridge and freezer temperatures were checked and within ranges, end-cooked meal temperature checks were completed and recorded and were within ranges as sighted on the app.

individual food, fluids and nutritional needs are met where this service is a component of service delivery.		The food service company has a winter and summer menu, which has been reviewed by a dietitian. All meals are plated and delivered to dining rooms in hot boxes. Special diets, or alternatives are labelled. Healthcare assistants serve the residents' meals in the dining rooms following Covid-19 restrictions. The food service company are responsible for ensuring that all kitchen staff are trained in safe food handling and that food safety procedures were adhered to. Staff were observed assisting residents with their lunchtime meals and drinks. Diets are modified as required and likes and dislikes are catered to. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the registered nurses or nurse manager. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings and surveys allow the opportunity for resident feedback on the meals and food services generally. Residents and relatives interviewed indicated satisfaction with the food service. The food satisfaction survey evidenced overall satisfaction with the food service. The director of the catering company attends resident meetings for feedback around food services. Snacks are supplied and available 24 hours per day in the dementia unit.
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 alters, the RN initiates a review and if required a GP visit. Residents and relatives interviewed stated their needs were being appropriately met. On the day of the audit there were 13 wounds including grazes, skin tears, and incontinence associated dermatitis excoriation. There were three stage 1 pressure injuries, three stage 2 pressure injuries, one stage 3, one non-facility acquired stage 4 pressure injury (which the district nurses are attending to), and one suspected deep tissue injury. All wounds had associated incident reports documented and all wound charts were documented electronically and included an assessment, wound management plan and evaluations with photographs taken at regular intervals evidencing progression towards healing. The wound care specialist was involved with the deep pressure injuries and section 31 notifications were completed appropriately. The progress notes documented by the GP indicated the pressure injuries and management were discussed. All pressure relieving equipment was implemented for residents with or at risk of acquiring a pressure injury. The healthcare assistants described performing skin checks at least each shift. Turning charts were maintained. And there was evidence of early reporting and management of any skin changes. Continence products are available and resident files included 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 by the RNs interviewed. Electronic monitoring forms in place included (but were not limited to): monthly weight, blood pressure and pulse, food and fluid charts, repositioning, blood sugar levels, wound charts, and behaviour charts.

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 one activities assistant (currently on leave) employed at Radius Fulton. The diversional therapist works across the rest home/hospital area and the dementia (Glenedin) unit. The diversional therapist and the activities assistant have completed the required dementia standards. Residents have a leisure and lifestyle profile assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career, and family. A plan documenting appropriate activities to support behaviour management had been completed for dementia residents. Leisure care plans are reviewed at least six-monthly. There is a monthly planner for each unit which is displayed on all noticeboards around the facility and in each resident's room. Group activities are integrated between the rest home/hospital residents and the residents form the Glenedin unit. Activities in the Glenedin unit are run over seven days a week, activities include arts and crafts, newspaper reading and discussion, word games, walks. The residents from the Glenedin unit are invited to join the group activities including bowls, housie, and van rides with the residents in the rest home/hospital area. During the audit, residents were observed to be enjoying the Christmas party in the main lounge/dining area, and those residents who chose not to participate in the activities in the main lounge were observed to 'potter' in the Glenedin unit reading the newspaper, listening to music, and setting tables in the dining room. Healthcare assistants in the dementia unit have access to equipment and provide a variety of activities when the activities staff are not present. Twenty-four-hour care plans are in place in the Glenedin (dementia) wing. Activities in the rest home/hospital area include (but is not limited to); individual activities, newspaper reading and discussions, reminiscing, baking, jazzersize, van outings, board games and puzzles. The programme is flexible and can be changed to reflect the residents needs on the day. The residents continue to participate in the two weekly 'slot' at the local radio station and residents across the facility have the opportunity to participate. The resident meetings provide an opportunity to discuss the activities programme to include new suggestions from residents, and gauge what the residents want to do. The diversional therapist explained, the activities are more resident led in the rest home/hospital area. Younger residents are considered in the activities planner. The diversional therapist visits all or most residents throughout the day to include some one-on-one activities of residents choosing. All residents are supported to continue to attend their groups they have always been part of. The current residents who are under 65 enjoy trips to art classes, listening to music through the iPad, spending time with family. One younger resident is active in the community throughout the day and sits with the residents in the lounge later in the evening. During the audit, residents were observed being actively involved with a variety of activities in the hospital, rest home and the dementia unit. The residents and relatives interviewed were complimentary of the current activities programme and were aware of the suggestion box to add any suggestions or new ideas. The 2021 satisfaction

		survey evidenced 85% satisfaction with the activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care-plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Any updates required to care plan interventions following the care plan evaluation in case conference, is updated in the care plan. Leisure (activity) plans are in place for each of the residents and these are also evaluated six-monthly. The case conference reviews involve the RN, GP, resident, and relatives if they wish to attend. Short term care plans are evaluated and updated in a timely manner. If the concern is ongoing, interventions are moved to the long-term care plan. There is at least a three-monthly review by the GP. The relatives 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 service displays a current building warrant of fitness, which expires on 3 March 2022. Hot water temperatures are checked monthly with tempering valves adjusted if resident taps exceed 45 degrees Celsius. Medical equipment and electrical appliances are regularly tested, tagged, and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior areas are well maintained with safe paving, outdoor shaded seating, and gardens. In the secure dementia wing, there are two secure outside courtyards, one on either side of the communal spaces. HCAs interviewed confirmed there is adequate equipment to carry out the cares according to the resident needs as identified in the care plans.
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 the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary which are benchmarked throughout the Radius organisation. Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the village manager and all staff in the nurse's station. An internal audit around infection control held in November 2021 evidenced 100% compliance. There was one outbreak of RSV in 2021. This was well managed and reported appropriately. Daily logs were maintained, staff and relatives were kept informed. Radius has developed policies, procedures and updated the pandemic plan to include Covid-19. There is a scanning machine which checks temperature, gains a wellness check and contact tracing information. QR codes are visible for all visitors and contractors to scan on entry to the facility. All visitors and contractors are required to

		check in using the scanning machine. Visiting is by appointment only in line with current Covid regulations. All visitors and contractors are required to provide evidence of vaccine status, and anyone without a vaccine status cannot visit the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	A registered nurse is the designated restraint coordinator. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. At the time of the audit, there were three (hospital level) residents voluntarily using enablers (bedrails) and three (hospital level) residents using restraint (two bedrails, one (prn) lap-belt). One file of a resident using an enabler (bedrails) was reviewed. The resident has given written consent for the use of bedrails to help them feel safe in bed. This enabler was linked to the resident's care plan, risks associated with bedrails are identified, and the enabler is regularly reviewed. Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours and includes annual competency assessments.

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.

No data to display

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 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	CI	The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of corrective actions. There is evidence of action taken based on corrective actions that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. The achievement of the rating that service implements a robust corrective action planning process addressing residents who are either falling or at risk of falling is beyond the expected full attainment.	A corrective action plan addressing residents’ falls reflects ongoing strategies to maintain a low falls rate. The falls group meets monthly. Strategies implemented by staff include (but are not limited to) staggering lunch times for staff, allowing for better staff cover during mealtimes, the use of vitamin D, ongoing training in falls prevention, physiotherapy input two days per week and the implementation of specific action plans to address those residents who are at risk of falling. ‘Fall-free’ celebrations take place with graphs posted (Stand up to Falls) in each staffroom to indicate which residents (if any) are falling. Falls rates for the facility remain below 10 falls/1000 bed nights with the falls rate for residents who have not fallen more than twice/month below 5 falls/1000 bed nights.

End of the report.