

Radius Residential Care Limited - Radius Thornleigh Park

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

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| Legal entity: | Radius Residential Care Limited |
| Premises audited: | Radius Thornleigh Park |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 12 June 2017 End date: 12 June 2017 |
| 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: | 50 |

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

General overview of the audit

Radius Thornleigh Park is owned and operated by Radius Residential Care Limited and cares for up to 63 residents requiring rest home and hospital, including medical, level of care. On the day of the audit there were 50 residents. The service is managed by a registered nurse with experience in aged care management. She is supported by a clinical manager/registered nurse with experience in aged care. The team is supported by a regional manager.

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 process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and the general practitioner.

Three of the nine previous audit findings have been addressed relating to complaints management, six monthly interRAI assessments and fridge and freezer temperature monitoring.

Six previous findings remain around documented evidence of resident/relative input into care plans, interRAI assessments for new admissions, documented care plan interventions, implementation of interventions, aspects of medicine management and six-monthly fire drills.

This audit has identified an area for improvement around meeting minutes.

Consumer rights

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| 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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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

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| 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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A facility manager and clinical nurse manager are responsible for the day-to-day operations. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities, including Radius key performance indicators, are conducted and this generates improvements in practice and service delivery. 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. An orientation programme is in place for new staff. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care. Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

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| <p>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.</p> | | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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Registered nurses are responsible for all stages of provision of care. Initial assessments, care plans and evaluations are completed by a registered nurse within the required timeframe. Care plans are written in a way that enables all staff to follow their instructions. The general practitioner reviews the residents at least three monthly.

The activity programme is varied and interesting and includes outings, entertainment and links with the community and schools. Each resident has an individual activity plan that meets their recreational preferences.

Medication policies and procedures are in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. The general practitioner reviews the medication charts at least every three months.

Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are offered.

Safe and appropriate environment

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| 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. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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The building has a current warrant of fitness.

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there was one resident with restraint and no residents using 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.

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.

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 | 12 | 0 | 2 | 5 | 0 | 0 |
| Criteria | 0 | 37 | 0 | 2 | 5 | 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 |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>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. Complaint forms are available at reception. Seventeen complaints were made in 2016 and one complaint received in 2017 year to date. Two complaints made through the local district health board (DHB) in 2016 were investigated and followed up. The DHB sent letters stating that the complaints were closed off. All complaints reviewed have been signed off as resolved. A review of the complaints register evidences that the appropriate actions have been taken and the complainant received documented outcome of the complaint. The previous certification audit finding has been addressed.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p> | FA | <p>Five residents (three rest home and two hospital) interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Fourteen incident reports reviewed evidenced recording of family notification. Four relatives (rest home) interviewed, confirmed they are notified of any changes in their family member's health status. Bi-monthly resident meetings provide a forum for residents to discuss issues or concerns. Families are encouraged to visit. The facility has an interpreter policy to guide staff in accessing interpreter services.</p> |

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| communication. | | |
| <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> | FA | <p>Thornleigh Park is part of the Radius Residential Care Group. The service cares for up to 63 residents requiring hospital (including medical) and rest home level care. There are six dual-purpose beds. On the day of the audit there were a total of 50 residents, 37 residents receiving rest home level care (including one resident on a long-term support chronic health condition (LTSCHC) contract). There were 13 residents receiving hospital level care (including one younger person's resident on a LTSCHC contract and one younger person under Accident Compensation Corporation (ACC)/Ministry of Health).</p> <p>The Thornleigh Park business plan April 2017 to March 2018 is linked to the Radius Residential Care group strategies and business plan targets. The mission statement is included in information given to new residents. An organisational chart is in place. Comprehensive quarterly reviews are undertaken to report on achievements towards meeting business goals. The facility manager reports monthly to the regional manager on a range of operational matters in relation to Thornleigh Park including strategic and operational issues, incidents and accidents, complaints, health and safety.</p> <p>The facility manager is experienced in aged care and has been in the role for 18 months. An experienced clinical nurse manager who has been in the position for 18 months supports her. A regional manager supports the facility manager in the management role and was present during the audit. The facility manager has completed in excess of eight hours of professional development in the past 12 months.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</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 Thornleigh. Quality and risk performance is reported across facility meetings and to the regional manager. The facility manager advised that she is responsible for providing oversight of the quality programme. There is a monthly staff meeting where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff. Required actions and resolutions from facility meetings are not consistently documented. Resident meetings are bi-monthly. Annual resident and relative surveys are completed with results communicated to residents and staff.</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 clinical managers group, 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. 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> |

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| | | <p>Health and safety policies are implemented and monitored by the health and safety committee. The health and safety representative (maintenance person) confirmed his understanding of health and safety processes including recent law changes. He completed the external health and safety training in September 2016. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Radius has achieved tertiary level ACC Workplace Safety Management Practice. Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions.</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 (KPIs). There is a discussion of incidents/accidents at monthly staff and quality/health and safety meetings including actions to minimise recurrence (link also to 1.2.3.5). A review of fourteen incident/accident forms identified that forms are fully completed and include follow-up by a registered nurse (RN). Not all neurological observations are carried out as per protocol for any suspected injury to the head (link 1.3.6.1). Discussions with the facility manager and regional manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications with examples of situations provided.</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. Six staff files reviewed (one clinical nurse manager, one registered nurse (RN), three healthcare assistants (HCA) and one maintenance person) include a comprehensive 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.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. 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. All staff participate in continuing education relevant to physical disability and young people with physical disabilities. There is an attendance register for each training session and an individual staff member record of training. Three of six RNs have completed their InterRAI training. The other RNs are booked to complete the training.</p> |

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| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>A policy is in place for determining staffing levels and skills mix for safe service delivery. There is a full-time facility manager and clinical nurse manager who work from Monday to Friday. There is a minimum of one RN on site at any time. There is one RN on duty in the morning shift, the afternoon shift and the night shift in the hospital area. In the rest home, there is one RN on the morning shift, the RNs from the hospital cover the afternoon and nights shifts in the rest home area. The RNs are supported by adequate numbers of HCAs. There are two HCAs on duty on the AM shift, two on the PM shift and two on the night shift in the hospital area (13 residents). There are four HCAs on duty on the AM shift and three on the PM shift in the rest home area (37 residents). Residents and family members interviewed report there are sufficient staff numbers.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | <p>PA Moderate</p> | <p>The medication management policies and procedures comply with medication legislation and guidelines. Registered nurses administer medications and have completed annual competencies and education. Healthcare assistants' complete competencies for the checking of medications. Medications are checked on delivery against the pharmacy generated medication charts by the RNs. Medicines are appropriately stored in accordance with relevant guidelines and legislation. One rest home resident who self-administers has a current competency assessment that has been reviewed three-monthly. The medication fridge temperature is monitored weekly. This is an improvement on the previous audit. Expiry dates of medications is checked monthly, however there were medications in the fridge that had expired. Weekly medication checks have occurred as needed.</p> <p>Ten medication charts (four hospital and six rest home) met prescribing requirements and had been reviewed by the GPs at least three monthly. 'As required' medications had indications for use, this is an improvement on the previous audit.</p> <p>Medication prescribed is signed as administered on the pharmacy generated signing chart. The discontinuation of one medication had not been signed or dated. The previous around prescribing and administration of medication remains. One signing sheet instructions did not align with the prescription.</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</p> | <p>FA</p> | <p>There is a fully functional kitchen and all food is cooked on site. There is a qualified chef, cooks and kitchenhands employed who have attended food safety and chemical safety training. There is an organisational four-week winter/summer menu that has been reviewed by the dietitian. Meals are served from a bain marie in the rest home and transported in hot boxes to resident rooms and other smaller dining areas within the facility. A resident dietary requirement profile is developed for each resident on admission and provided to the kitchen staff. The chef is notified of any changes to resident's dietary requirements. Resident dislikes are known and accommodated. Special diets accommodated include diabetic desserts and modified/pureed diets. There is a vegetarian option for the midday and evening meal. Temperatures of end-cooked foods are monitored and</p> |

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| <p>delivery.</p> | | <p>recorded twice daily.</p> <p>The temperatures of all facility refrigerators and freezers are recorded. The previous finding has been addressed. The chemical provider services and monitors the use of chemicals for the dishwasher. A cleaning schedule is maintained.</p> <p>Residents and the family members interviewed were satisfied with the meals and have the opportunity to feedback through meetings and surveys.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | <p>PA Moderate</p> | <p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Initial assessments were completed on admission. Six monthly routine interRAI assessments had been completed in two resident files (one hospital and one rest home). One hospital resident under LTCHC was not required to have an interRAI assessment. Two rest home residents did not have an interRAI assessment completed within 21 days. Care plans are developed on the outcomes of these assessments and paper based assessments (link 1.3.5.2). One rest home resident did not have an interRAI assessment completed for a change in health status. The previous finding around assessments remains.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>PA Moderate</p> | <p>Long term care plans describe the resident problems, goals and nursing interventions required to meet the resident's needs however not all plans care were current. Short term care plans are in use for changes in health status. These are reviewed regularly with problems either resolved or if ongoing added to the long-term care plan. Staff interviewed reported they found the plans easy to follow. The previous finding around care plans remains</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> | <p>PA Moderate</p> | <p>Registered nurses (RNs) and HCAs follow the care plans and report progress against the care plan each shift. If a resident's health status changes the RN initiates a GP or nurse specialist review. Relatives interviewed state they are contacted for any changes in the resident's health.</p> <p>Staff have access to sufficient medical supplies including dressings. Wound assessments, evaluation notes and photographs were in place for ten residents with wounds including skin tears, one chronic ulcer and one resident with four pressure injuries (one stage three and three stage four). There is documented evidence of specialist nursing wound care management advice and district nursing service involvement in the management of wounds. Wound were reviewed within set time frames. This aspect of the previous finding has been addressed.</p> <p>Sufficient continence products are available and resident files include a continence assessment and plan.</p> |

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| | | <p>Specialist continence advice is available as needed and this could be described</p> <p>Monitoring forms are available, however a shortfall was identified around implementing monitoring forms. The previous finding around interventions remains.</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>A full-time activities coordinator and part-time activity coordinator (20 hours) are employed to coordinate and implement an integrated rest home/hospital activities programme from Monday to Friday. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities are held in the main lounge. One activity coordinator spends one-on-one time with residents who choose not to or unable to participate in group activities. The younger persons have individualised activities that are age appropriate including outings, play station, computers and access to Ironsides transport for community outings.</p> <p>Entertainers, guest speakers and hearing dogs visit the home. Special events and theme days are celebrated. Fortnightly interdenominational church services are held. Group activities reflect ordinary patterns of life and include planned visits to the community and other rest homes. The service has a wheelchair van.</p> <p>Residents and families interviewed commented positively on the activity programme. They have the opportunity to feedback on the programme through monthly resident/relative meetings and surveys.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>All initial care plans are evaluated by the registered nurses within three weeks of admission. In files reviewed, the long-term care plan was evaluated at least six monthly against the resident goals. There is at least a three-monthly review by the GP. Written evaluations identify if the resident/relative goals are met or unmet. 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 reviewed.</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</p> | FA | <p>The facility has a current building warrant of fitness which expires 5 May 2018.</p> |

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| their purpose. | | |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | PA Moderate | Fire evacuation drills have not taken place every six months. The previous certification audit finding has not been addressed. |
| <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>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection reports are completed for all infections including suspected infections that are not treated with antibiotics. Infection control data and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>Infection control data, trends and analysis is discussed at the monthly clinical and staff/management meetings. Data is sent to head office where the facility is benchmarked against other Radius facilities of similar sizes. Internal audits for infection control are included in the annual audit schedule</p> <p>There has been one confirmed norovirus outbreak in March 2017 which was managed. Relevant authorities were notified. The service identified a need for isolation buckets set up with equipment to be readily available. Quality improvements have been implemented.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there was one resident with restraint (bedrail) and no residents using an enabler. All necessary documentation is available in relation to the restraints. Staff training has been provided around restraint minimisation and the management of challenging behaviours. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. |

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) |
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| Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system. | PA Low | Discussions with the facility manager, clinical nurse manager and staff, and review of management and staff meeting minutes demonstrate their involvement in quality and risk activities. | Not all facility meetings have been completed as per annual meeting calendar schedule. Required actions and resolutions have not been consistently documented, followed up or completed. | Ensure that all facility meetings are completed as per annual meeting calendar schedule and any required actions are followed up or completed. 90 days |
| Criterion 1.3.12.1 | PA | The service has policies and procedures in place to safely guide staff. The medication fridge temperature | 1) Three of four glucagon kits had expired. 2) The signing sheet for one 'as required' | 1) Ensure all expiry dates of |

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| <p>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.</p> | <p>Moderate</p> | <p>is monitored weekly. Medications in the fridge had expired. Medications are administered as prescribed however the signing sheet for one medication did not align with the prescription. The discontinuation of the one medication had not been signed or dated.</p> | <p>controlled drug did not align with the medication chart. 3) One discontinued medication had not been dated or signed by the GP.</p> | <p>medications are checked and medication removed if out of date. 2) Ensure signing sheets align with the prescription. 3) Ensure all medications are dated and signed when discontinued.</p> <p>30 days</p> |
| <p>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.</p> | <p>PA Low</p> | <p>Staff receive verbal and written handovers between the shifts that ensures a continuity of care delivery. Care plans are developed to describe the resident goals and interventions/supports required to meet their needs. Four care plans evidenced resident/relative input into the care plans.</p> | <p>There was no documented evidence of relative/resident input into the care plan for one younger person with a long-term chronic health condition.</p> | <p>Ensure there is documented evidence of resident/relative input into the resident's care plan.</p> <p>180 days</p> |
| <p>Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are</p> | <p>PA Moderate</p> | <p>Completed assessments and the outcomes from the long-term care plan, however first interRAI assessments for two residents were not completed within 21 days of admission. One resident did not have an interRAI assessment completed for a change to health.</p> | <p>Two rest home level residents did not have an interRAI assessment within 21 days of admission. An interRAI assessment had not been completed for one rest home resident with changes to health requiring re-assessment for higher level of care.</p> | <p>Ensure interRAI assessments are completed within 21 days of admission. Ensure interRAI assessments are completed for residents</p> |

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| documented to serve as the basis for service delivery planning. | | | | with changes to health status. 90 days |
| Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The long-term care plans reviewed for one rest home and two hospital residents described the support required to meet the resident's goals as identified by the ongoing assessment process and needs. Not all allied health involvement was linked to the long-term care plans. Residents and their family/whānau interviewed confirm they are involved in the care planning and review process (link 1.3.3.4). Short-term care plans are in use for changes in health status. These are reviewed regularly with problems either resolved or if ongoing, added to the long-term care plan. Staff interviewed reported they found the plans easy to follow. The previous finding around care plans remains. | 1) The care plan for one rest home resident had not been updated to reflect additional supports required following a hospital admission including the use of oxygen and pressure injury prevention for high risk of pressure injury. A dietitian referral had been actioned, however there was no report or dietary recommendations included in the resident file or care plan. 2) The care plan for another rest home resident did not reflect falls prevention interventions for moderate risk of falls and absconding incidents necessitating and re-assessment for higher level of care. | Ensure care plans reflect the resident needs/supports and current health status. 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 Moderate | Monitoring forms available for use include weight, vital observations, food and fluid, blood sugar levels, behaviour, intentional rounding and neurological observations. Monitoring had not been implemented for three residents. | 1) There were no weekly weights for one hospital younger person under LTCHC with unintentional weight loss. 2) Intentional rounding had not been completed half hourly for two rest home residents as per care plan instructions. 3) Neurological observations had not been completed for three residents as per protocol following unwitnessed falls. | Ensure interventions are implemented for the monitoring of a resident's health status. 60 days |
| Criterion 1.4.7.1 Service providers receive appropriate | PA Moderate | Staff have had training around fire safety and the management of other emergencies. There was a fire evacuation drill on 28 February 2017. | The latest fire evacuation drill on 28 February 2017 occurred later than the required six-month period. | Ensure that fire evacuation drills are |

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| information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | | | | conducted at least six-monthly. 30 days |
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.