

Radius Residential Care Limited - Radius Elloughton Gardens

Current Status: 3 February 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Radius Elloughton Gardens is part of the Radius Residential Care Group. Elloughton Gardens provides care for residents requiring hospital, and rest home level care. On the day of the audit there were 31 residents receiving hospital level care and 28 receiving rest home level care.

The facility manager is a registered nurse who is experienced in aged care and has been in the role for since April 2013. The clinical manager who has been in the position for two months supports the facility manager as does the regional manager. Families and residents spoke highly of the care provided at Elloughton Gardens.

The two shortfalls identified at the previous audit continue to require improvement. These were around care planning and aspects of medication management.

This audit has identified further improvements required around calibration of medical equipment, wound documentation and restraint monitoring.

Audit Summary as at 3 February 2014

Standards have been assessed and summarised below:

Key

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

Consumer Rights as at 3 February 2014

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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Organisational Management as at 3 February 2014

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.
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Continuum of Service Delivery as at 3 February 2014

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.
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Safe and Appropriate Environment as at 3 February 2014

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 low risk.
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Restraint Minimisation and Safe Practice as at 3 February 2014

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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Infection Prevention and Control as at 3 February 2014

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Radius Residential Care Limited		
Certificate name:	Radius Residential Care Limited - Radius Elloughton Gardens		
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Radius Elloughton Gardens		
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
Dates of audit:	Start date: 3 February 2014	End date: 4 February 2014	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			59

Audit Team

Lead Auditor	XXXXX	Hours on site	11	Hours off site	6
Other Auditors		Total hours on site		Total hours off site	
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	11	Total audit hours off site	8	Total audit hours	19
Number of residents interviewed	5	Number of staff interviewed	10	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	59	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Friday, 7 March 2014

Executive Summary of Audit

General Overview

Radius Elloughton Gardens is part of the Radius Residential Care Group. Elloughton Gardens provides care for residents requiring hospital, and rest home level care. On the day of the audit there were 31 residents receiving hospital level care and 28 receiving hospital level care.

The facility manager is a registered nurse who is experienced in aged care and has been in the role for since April 2013. An experienced clinical manager who has been in the position for two months supports her. The regional manager (a registered nurse) also supports the facility manager. Families and residents spoke highly of the care provided at Elloughton Gardens.

The two shortfalls identified at the previous audit continue to require improvement. These were around care planning and aspects of medication management.

This audit has identified further improvements required around calibration of medical equipment, wound documentation and restraint monitoring.

Outcome 1.1: Consumer Rights

There is an open disclosure policy and an interpreter's policy in place. Staff have a good understanding of these policies. Interpreter services are available if needed. Families of the resident's report the manager and staff keep them informed of their family member's status. Incident forms identify family is informed and this is an improvement on previous audit.

There is a complaints policy supporting practice and a complaints register. Resident and family interviews confirmed their understanding of the complaints process. There has been one Health & Disability Commission (HDC) complaints. This has been closed with no further action required.

Outcome 1.2: Organisational Management

Radius has an organisational philosophy, which includes a vision, mission statement & objectives including a quality/risk management framework & process policy. The manager is suitably qualified in her role.

There is evidence that the quality system continues to be implemented at Elloughton Gardens.

The service's policies are reviewed two yearly. Staff have access to manuals in hard copy and over the intranet. Policies are up to date.

Clinical guidelines are in place to assist care staff. The service collects internal data for monitoring purposes. Results are benchmarked against other Radius facilities. Staff are informed of internal audit results. There is documented evidence of corrective action plans in place for internal audits.

The service has a risk management programme. There is an organisational risk register in place. All clinical events are being documented including pressure areas. Monthly aggregation of incident data (resident falls, skin tears, pressure areas, challenging behaviours and medication incidents) is undertaken and sent to Radius Head Office for benchmarking purposes.

Practising certificates are held in a central location for all registered, clinical staff. A recruitment, selection and appointment of staff policy are in place.

Elloughton Gardens staff orientation programme is specific to the worker type and has been completed by all staff. A comprehensive training schedule is in place, directed from the head office.

An acuity and clinical staffing ratio policy is in place that includes a documented rationale for staffing the service. Staffing is designed to match the needs of the residents.

Outcome 1.3: Continuum of Service Delivery

Registered nurses are responsible for each stage of service provision. The sample of residents' records reviewed provides evidence that the provider has systems to assess and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified for some residents and these are reviewed with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration and guide all staff in cares. Care plans are reviewed six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. There are improvements required around documenting care plan interventions, restraint monitoring and wound documentation. All staff responsible for administration of medicines complete education and medicines competencies. There are policies and procedures around medication management and residents self-medicating. There are improvements required around administration documentation, dating eye drops when opened and general practitioner prescribing documentation. The activities programme provides varied options and activities are enjoyed by the residents. Each resident has an individualised plan. Community activities are encouraged; van outings are arranged on a regular basis. All food is cooked on site. All residents' nutritional needs are identified, documented and choices provided. Meals are well presented, homely and a dietitian has reviewed the menu plans. Food and fridge temperatures are recorded. Residents have a nutritional assessment completed on admission and dietary requirements with likes and dislikes are recorded.

Outcome 1.4: Safe and Appropriate Environment

The facility building warrant of fitness was sighted and is current. Preventative and reactive maintenance occurs. There is an improvement required around calibrating medical equipment.

Outcome 2: Restraint Minimisation and Safe Practice

The service has separate restraint and enabler registers for each unit that include the type of restraint/enabler, date commenced and comments. The registers are reviewed at the restraint committee meetings and a previously required shortfall around comprehensive review of restraint practice has been met.

Outcome 3: Infection Prevention and Control

There is a dedicated infection control coordinator who has a role description. The infection control coordinator collates monitoring data and reports through to the quality and risk management meetings and outcomes are reported to staff through nursing and staff meetings. Infection control surveillance is established that is appropriate to the size and type of services.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	13	0	2	2	0	0
Criteria	0	38	0	2	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	33
Criteria	0	0	0	0	0	0	0	59

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	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	(i) Of the five files sampled three did not include interventions related to all identified needs for the resident. One care plan did not address epilepsy, depression and stated that the resident has thin fluids when in fact they now require thickened fluids and a pureed diet, one care plan has not been updated to include exercises recommended by the physiotherapist and one care plan does	Ensure care plans reflect current needs for all residents.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				not address the residents depression. One resident has a short term care plan that has not been evaluated and closed despite the issues being resolved.		
HDS(C)S.2008	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			
HDS(C)S.2008	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	(i)One resident has three pressure areas. Two of these pressure areas are documented on the same assessment, management plan and review chart making it difficult to distinguish between the two wounds. (ii)Two of the 19 wounds have not been reviewed within the stated timeframes. (iv) Two of the three restraint monitoring forms sampled have not been completed to show regular restraint monitoring.	(i)Ensure that all wounds have an individual wound assessment, management plan and review documentation. (ii) Ensure all wounds are reviewed within stated timeframes. (iv) Ensure that residents with restraint are monitored in the documented timeframes.	60
HDS(C)S.2008	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			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and	PA Moderate	(i) Six of ten medication charts sampled have regular non packaged	(i) Ensure medications are administered as prescribed. (ii) Ensure all eye drops are	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		medications that have not always been signed as administered. (ii) One of ten open eye drops in use has not been dated when it was opened.	dated when they are opened.	
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	Medical equipment has not been calibrated.	Ensure medical equipment is calibrated according to manufacturer's instructions.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

There is an open disclosure policy. The communication with residents policy includes procedures to ensure that staff communicate well with residents and family members. There are monthly resident/relative meetings facilitated by the activities staff allowing residents/relatives to raise issues. Five residents (three from the rest home and two from the hospital) stated they were welcomed on entry and were given time and explanation about services and procedures.

Eighteen incident reports were reviewed across the service. All recorded family notification. Five relatives interviewed (three from the rest home and two from the hospital) informed they are notified of any changes in their family members health status. The clinical manager, who investigates incidents, informed there are processes in place to support family notification of events.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry.

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b: All five relatives stated that they are informed when their family members health status changes.

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.

D11.3 The information pack is available in large print and advised that this can be read to residents.

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Attainment and Risk: FA

Evidence:

The complaints policy and procedure states that clients/family/whanau shall have access to a complaints system whereby they can express concern without prejudice and those concerns are addressed. Residents/family can lodge formal or informal complaints through verbal communication, written, resident meetings, complaint forms or via suggestion box.

A clients complaint procedure flow chart is included in the policy and is included in the information pack for residents on entry. Policy states that complaints process is to be visible and available in public areas.

Interviews with five residents (three from the rest home and two from the hospital) and five relatives (three from the rest home and two from the hospital) were familiar with the complaints procedure and state all concerns /complaints are addressed.

The complaints log/register includes date of incident, complainant, summary of complaint, signature off as complete. There have been six complaints in 2013. All have documentation of full investigation and resolution including communication with complainants is documented for all complaints. One of these complaints relating to a residents care was investigated by the Health and Disability Commission, commencing in June 2013. As a result of the complaint 25 of the 30 care staff have completed manual handling training, a physiotherpaist has been contracted for four hours per week, all staff have had training on rights and elder abuse and staff training around workplace bullying is booked for 24 and 25 May 2013. In October 2013 the Health and Disability Comission advised the service and the complainant that no further action is required.

D13.3h. A complaints procedure is provided to residents within the information pack at entry.

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Attainment and Risk: FA
Evidence: <p>Elloughton Gardens is part of the Radius Residential Care Group. Elloughton Gardens care for residents requiring hospital and rest home level care. On the day of the audit there were 28 residents receiving rest home level care and 31 receiving hospital level care.</p> <p>The facility manager is a registered nurse who has been with Radius for three years and has been the facility manager at Elloughton Gardens since April 2013, having previously held clinical manager roles. She is supported by a very experienced clinical manager who has been in the role for two months. The facility manager has completed a number of business and management papers at Lincoln University. The facility manager reports monthly to the regional manager on a range of operational matters in relation to Elloughton Gardens including strategic and operational issues, incidents and accidents, complaints, health and safety. Radius mission statement states that:</p> <p>"We deliver a quality lifestyle with an innovative approach to care that enables us to maintain the wellbeing, dignity and independence of our residents"</p> <p>Radius has an organisational philosophy, which includes vision, mission statement & objectives including quality/risk management framework & process policy. Annual business quality/risk management plans are in place (sighted for 2014). A quality/risk management plan for 2014 has been developed for Radius Residential Care and Elloughton Gardens has developed site specific objectives including:</p> <ol style="list-style-type: none">1. Clinical and Operational key performance indicators2. Clinical effectiveness

- 3. Consumer participation
- 4. Workforce effectiveness
- 5. Risk management
- 6. Taking ownership of the business and services provided
- 7. Effective financial leadership and management
- 8. Cost containment and reduction.

The service has a documented structure that supports continuity of management and care delivery.

ARC,D17.3di (rest home), D17.4b (hospital), The organisation provides annual conferences for their managers and annual regional conferences and the facility manager attended a mini conference and a full conference in 2013.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Attainment and Risk: FA

Evidence:

There is an organisational quality/risk management plan - 2014 that includes clinical/care related risks, human resources; health and safety; environmental/service; financial; as well as site specific risks/goals identified for Elloughton Gardens.

There is evidence that the quality system continues to be implemented at Elloughton Gardens. Staff have designated portfolios including incidents and accidents, training, restraint, health and safety and infection control. Interviews with five healthcare assistants (one who works in the hospital and four who work across all areas) and two registered nurses confirmed that quality data is discussed at monthly staff meetings (staff and RN meeting minutes reviewed). The facility manager advised that she is responsible for providing oversight of the quality programme. There is also a monthly quality meeting where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff.

The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed at national level by the clinical managers group with input from facility staff every two years. Clinical guidelines are in place to assist care staff with such issues as constipation, delirium, congestive heart failure, diabetes, dementia, falls prevention, incontinence, nutrition and hydration, skin care and wound management. Internal audits are completed for care delivery compliance, care plans compliance, clinical records, medications, hand washing, privacy.

D5.4 The service has the appropriate policies and procedures to support service delivery;

There are policies and procedures appropriate for service delivery. Policy manuals are reviewed two yearly. New/updated policies are sent from head office. New policies/procedures are put in the staff room with a signing sheet for staff to sign once they have read and understood the documentation (verified at interview with five healthcare assistants and two registered nurses). Staff have access to manuals (nurses stations and staff room). Policies are up to date and are located electronically on 'P' drive.

Monthly reports by the facility manager to the regional manager are provided on service indicators. The quality meetings are minuted and with a set agenda including (but not limited to): health & safety, incident and accidents, complaints/compliments. Information is taken to staff through the various meetings, staff notice boards.

a) There are monthly accident/incident reports completed by the facility manager that break down the data collected across the service.

b) The service has linked the complaints process with its quality management system. Monthly manager reports to the regional manager include complaints. Staff meeting minutes identify discussion of complaints.

c) There is an infection control data collection form which records all infections for each month. Infection control rates, outbreaks and results of internal audits are reported to the staff meeting and through clinical indicator reports for benchmarking. A range of infection control internal audits are planned and undertaken during the year. Results are forwarded to the staff, and registered nurse meetings.

d) Health and safety is an agenda item of the staff meeting. Any new hazards are discussed.

e) Advised that the restraint committee report through the quality and restraint meetings, feedback is provided to staff and RN meetings. Restraint use is also fed back to the organization through the clinical indicator reports. Restraint internal audits are completed yearly and results are also forwarded through monthly manager meetings. Radius benchmarks its own facilities against predetermined indicators that are reported monthly from facilities. Further evidence may be requested by the regional

manager when indicators are above the benchmark. The service collects internal monitoring data (internal audits) with the audit schedule being implemented at Elloughton Gardens by the facility manager.

Radius policy informs a corrective action plan is required where compliance is under a predetermined threshold. Corrective action plans were developed for incident reports (sighted) and all audits where there has been less than 95% conformity. The corrective action plans are also completed when the service notices a trend in any of the quality data. In June 2013 there was an increase in UTI's. A corrective action plan was opened and included ongoing interventions including staff education, increased cleaning, monitoring, increased fluids for at risk residents and individualised actions. The corrective action plan was closed in December when UTI rates had dropped.

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management

D19.2g: Falls prevention strategies such as aggregating data monthly that includes considering time of occurrence

There is emergency and disaster planning in place around earthquakes, fire, emergencies and other disasters. This includes training and education for staff, monthly building compliance checks, six monthly evacuation trials, and ensuring adequate staffing in the event of an emergency. There is an organisational risk register that includes identified risk and risk rating, identified action to prevent or minimize risk and persons responsible and covers areas such as clinical risk, human resources related risks, health and safety risks, environment/service related risks and financial risk. Each facility personalises to their site. Radius has a terms of reference for the health and safety committee defining membership to include healthcare assistants and a household representative.

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

The organisation has a quality and risk management system which is understood and implemented by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Attainment and Risk: FA

Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Attainment and Risk: FA
Evidence: As part of risk management and health and safety framework, there is an accident/incident reporting and open disclosure policy/procedure. There was evidence of indicator month by month data collection including (but not limited to): falls (no injury, soft tissue, fractures), skin tears, medication and pressure areas. Eighteen incident forms sampled evidence detailed investigations and corrective action plans following incidents including neuro observations for two residents who had hit their head. Actions taken to minimise risk to individual residents are recorded Monthly data is taken to the risk management and restraint meeting. The five healthcare assistants and two registered nurses interviewed could describe the process for management and reporting of incidents and accidents. D19.3b; There is an accident/incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Eighteen incident forms were reviewed across the service and clinical actions were well documented. Actions taken to minimise risk to individual residents are recorded D19.3c Discussions with the service (regional manager, and facility manager) confirms an awareness of the requirement to notify relevant authorities (DHB) in relation to essential notifications. Accident/incident analysis includes falls, skin tears, pressure areas, resident behaviour and medication incidents. The service has an incident and accident analysis form that includes name, place, date and time, type, injury/site, cause, resident/staff/visitor, doctor notified, hazards identified and action taken. Monthly aggregation of data is undertaken (falls monthly summary's sighted) and outcomes are discussed at all meetings - management, quality and staff meetings.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: FA

Evidence:

Of the five staff files reviewed, two were registered staff - current practicing certificates were able to be reviewed. The facility manager reported a system is in place to check expiry dates. New registered staff are required to provide a practising certificate as part of the recruitment process. Practising certificates are sighted for: GP's, physiotherapist, pharmacy, podiatrist and dietician.

Recruitment, selection and appointment of staff policy is in place. Five staff files were reviewed (one kitchen supervisor, one diversional therapist, the clinical manager, one registered nurse and one health care assistant) and all have a current performance appraisal.

The organisation has a staff orientation policy. Elloughton Gardens has an orientation programme that is specific to worker type and includes manual handling, health and safety in service and competency testing. The new staff member is then buddied for three shifts with an experienced healthcare assistant (HCA). The facility manager identifies suitably skilled HCA to be the 'buddy'. Interview of five healthcare assistants and two registered nurses informed there is an orientation process provided that included a period of being buddied.

In all five staff files reviewed there was a record that an orientation had been completed.

The service has an internal training programme directed by head office. There is an assigned in-service training manual that includes sessions required at orientation and then yearly. All sessions include a quiz which is used at Elloughton Gardens to embed information from the sessions provided. Challenging Behaviour and dementia

are part of the training programme.

In addition to training requirements there are healthcare assistant competencies (hand washing, manual handling, restraint, first aide) with a tracking sheet in place to monitor requirements. Sighted compliance audits of hand washing - signed off by a registered nurse and restraint competency quizzes completed for 2013.

D17.7d: Registered nurse competencies include: hand washing, manual handling, restraint, medication, CAPD, syringe driver. As for above a tracking process is in place to monitor requirements.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA

Evidence:

Acuity and clinical staffing ratio policy in place that includes a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty to match needs of different shifts. The facility manager and clinical nurse leader, both registered nurses work full time. Staff turnover is reducing following a period of moderate turnover when rostering practices were altered. The five healthcare assistants (one who works in the hospital and four who work across all areas and all who work mornings, afternoons and nights) and two registered nurses interviewed stated that there is adequate staffing to manage their workload on any shift. The GP was interviewed and confirmed that staffing is appropriate to meet the needs of residents. Five residents (three from the rest home and two from the hospital) and five relatives (three from the rest home and two from the hospital) interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent and friendly.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.3: Continuum of Service Delivery

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.

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Attainment and Risk: FA

Evidence:

There is a policy and process that describe resident's admission and assessment procedures.

A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission.

Activity assessments and the activities sections care plans have been completed by the diversional therapist.

A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment, c) continence assessment d) cultural assessment, e) skin assessment, f) and nutritional assessment and g) pain assessment.

Care plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed need (link 1.3.5.2). Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery.

All five files identified integration of allied health including district nurses, orthopaedics, oncology, DHB nurse specialist, physiotherapy and podiatry. The GP interviewed spoke very positively about the service and describes effective communication processes.

D16.2, 3, 4: The five resident files reviewed (two from the rest home and three from the hospital), identified that in all five files a nursing assessment was completed within 24 hours and five of five files identify that the long-term care plan was completed within three weeks. There is documented evidence that the care plan were reviewed by a registered nurse and amended when current health changes (link 1.3.5.2). Four of five care plans reviewed evidenced evaluations completed at least six monthly. One resident had been in the facility less than six months.

Tracer Methodology rest home:

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Tracer methodology hospital:

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

Attainment and Risk: FA

Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

Attainment and Risk: PA Moderate

Evidence:

The previous audit identified that long term care plans and short term care plans do not always document residents current needs. Of the five files sampled for this audit three did not include interventions related to all identified needs for the resident. One care plan did not address epilepsy, depression and stated that the resident has thin fluids when in fact they now require thickened fluids and a pureed diet, one care plan has not been updated to include exercises recommended by the physiotherapist and one care plan does not address the residents depression.

Short term care plans are well used for acute needs. Examples sighted in the five files include increased falls risk, skin tears, weight loss, recent surgery, pressure areas, chest infections, lack of safety in wheelchair, inappropriate sexual comments, wandering at night, recent bereavment, reintroduction of foods, maintaining adequate hydration and management of a PEG site. Fifteen of 17 short term care plans sampled have been either evaluated when the issue resolved or are continuing as the issue is still current. However one resident has a short term care plan that has not been evaluated and closed despite the issues being resolved.

There continues to be improvements required around care planning.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Attainment and Risk: PA Moderate

Evidence:

The previous audit identified that long term care plans and short term care plans do not always document resident's current needs. Of the five files sampled for this audit, two include interventions related to all identified needs for the resident.

Short term care plans are well used for acute needs. Examples sighted in the five files include increased falls risk, skin tears, weight loss, recent surgery, pressure areas, chest infections, lack of safety in wheelchair, inappropriate sexual comments, wandering at night, recent bereavement, reintroduction of foods, maintaining adequate hydration and management of a PEG site. Fifteen of 17 short term care plans sampled have been evaluated either when the issue resolved or are continuing as the issue is still current.

Finding:

(i) Of the five files sampled three did not include interventions related to all identified needs for the resident. One care plan did not address epilepsy, depression and stated that the resident has thin fluids when in fact they now require thickened fluids and a pureed diet, one care plan has not been updated to include exercises recommended by the physiotherapist and one care plan does not address the residents depression. One resident has a short term care plan that has not been evaluated and closed despite the issues being resolved.

Corrective Action:

Ensure care plans reflect current needs for all residents.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Attainment and Risk: PA Low

Evidence:

The service provides services for residents requiring rest home and hospital level care. Five resident files (two from the rest home and three from the hospital) , were reviewed for this audit: Care plans evidenced at least six monthly care plan reviews. The use of short term care plans are evident (see CAR 1.3.5.2 relating to short term care plan evaluations). The care being provided is consistent with the needs of residents, this is evidenced by discussions with five health care assistants who work both am and pm shifts and who work across rest home and hospital, five relatives (three from the rest home and two from the hospital), two registered nurses, the clinical manager (RN) and the facility manager. A review of food and fluid charts, 30 minute checking charts and resident turning charts indicate that residents needs are being met. Three restraint monitoring forms were reviewed and two of the three have not been completed to show regular restraint monitoring. This is an area requiring improvement. The GP interviewed stated the facility applied changes of care advice immediately and was highly complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission. There is evidence of referrals to specialist services such as podiatry, physiotherapy, speech language therapist, dietitian, district nurses and gerontology nurse specialist. There is also evidence of community contact. D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. 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. Continence management in-services and wound management in-service have been provided. Wound assessment and wound management plans are in place for 19 residents with wounds. One residents has three pressure areas. There are no other pressure areas at the facility. Two of these pressure areas are documented on the same assessment, management plan and review chart making it difficult to distinguish between the two wounds. Two of the 19 wounds have not been reviewed within the stated timeframes. These are areas requiring improvement. On interview the two and the clinical manager stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required. There is evidence in files of the wound specialist referrals and one resident is currently under the district nursing service for wound management.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: PA Low

Evidence:

The service provides services for residents requiring rest home and hospital level care. Five resident files (two from the rest home and three from the hospital), were reviewed for this audit:

Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management plans are evident. Care plans evidenced at least six monthly care plan reviews. The use of short term care plans is evident (see CAR 1.3.5.1 relating to short term care plan evaluations). The care being provided is consistent with the needs of residents, this is evidenced by discussions with five health care assistants who work both am and pm shifts and who work across rest home and hospital, five relatives (three from the rest home and two from the hospital), two registered nurses, the clinical manager (RN) and the facility manager. The GP interviewed stated the facility applied changes of care advice immediately and was highly complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission.

There is evidence of referrals to specialist services such as podiatry, physiotherapy, speech language therapist, dietitian, district nurses and gerontology nurse specialist. There is also evidence of community contact.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

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.

Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for 19 residents with wounds. On interview the two and the clinical manager stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required. There is evidence in files of the wound specialist referrals and one resident is currently under the district nursing service for wound management.

Finding:

(i)One resident has three pressure areas. Two of these pressure areas are documented on the same assessment, management plan and review chart making it difficult to distinguish between the two wounds. (ii)Two of the 19 wounds have not been reviewed within the stated timeframes. (iv) Two of the three restraint monitoring forms sampled have not been completed to show regular restraint monitoring.

Corrective Action:

(i)Ensure that all wounds have an individual wound assessment, management plan and review documentation. (ii) Ensure all wounds are reviewed within stated timeframes. (iv) Ensure that residents with restraint are monitored in the documented timeframes.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Attainment and Risk: FA

Evidence:

The diversional therapist employed by the service has worked at Elloughton Gardens for three years and works 37.5 hours over five days. She is supported by an activities assistant who works 15 hours over two days. All recreation/activities assessments and reviews are up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge. 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 and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Activities include entertainers, crafts, exercise, music/sing alongs, bingo movies and outings. There are also visits from community groups including a number of local schools.

All five relatives interviewed (three from the rest home and two from the hospital) stated that activities are appropriate and varied enough for the residents. All five residents (three from the rest home and two from the hospital) interviewed stated they were happy with the activities available and are given a choice regarding attendance.

D16.5d: Four resident files reviewed identified that the individual activity plan is reviewed at the time of care plan review. One resident file viewed had been in the facility less than six months.

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA

Evidence:

D16.3c: All initial care plans were developed by an registered nurse within three weeks of admission and evaluated at least six monthly or if there is a change in health status. There is a three monthly review by the GP. There was documented evidence that evaluations were up to date in all five care plans reviewed. Overall changes in health status are documented and followed up. Care plan reviews are signed as completed by a registered nurse. GP's review residents medication at least three monthly or when requested if issues arise or health status changes.

D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Attainment and Risk: PA Moderate

Evidence:

There are policies and processes that describe medication management that align with accepted guidelines. Medications are checked against the doctor's medication profile on arrival from the pharmacy by a registered nurse. Any mistakes by the pharmacy are regarded as an incident. Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. Resident medication charts are identified with demographic details and photographs. The fridge that medications are kept in has a weekly temperature check. Allergies are identified on the medication record. All ten medication charts had allergies (or nil known), documented. The service documents adverse reactions and errors on incident/accident forms. All medication charts clearly document an indication for use for all as required medications prescribed. This is an improvement since the previous audit. Six of ten medication charts sampled have regular non packaged medications that have not always been signed as administered. This is an area requiring improvement.

There is a locked cupboard that is used for controlled drugs in both the rest home and the hospital. There are drug trolleys that are kept in the nurses' station in each area which are locked when not in use.

One of ten open eye drops in use has not been dated when it was opened. This is a previously identified shortfall that continues to require improvement.

Medication round observed; all practice is appropriate.

A medication competency has been completed annually by all staff who administer medication.

There is a policy and process that describes self-administered medicines. There are currently no residents who self-administer medication.

D16.5.e.i.2: Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

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.

Attainment and Risk: PA Moderate

Evidence:

There are policies and processes that describe medication management that align with accepted guidelines. Medications are checked against the doctor's medication profile on arrival from the pharmacy by a registered nurse. Any mistakes by the pharmacy are regarded as an incident. Resident medication charts are identified with demographic details and photographs. The fridge that medications are kept in has a weekly temperature check. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication record. All medication charts clearly document an indication for use for all as required medications prescribed. This is an improvement since the previous audit. A locked cupboard is used for controlled drugs in both the rest home and the hospital. Weekly controlled drug stocktakes have occurred in both areas. There are drug trolleys that are kept in the nurses' station in each area which are locked when not in use.

Medication round observed; all practice is appropriate.

A policy and process describe self-administered medicines. There are currently no residents who self-administer medication.

D16.5.e.i.2: Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

Finding:

(i) Six of ten medication charts sampled have regular non packaged medications that have not always been signed as administered. (ii) One of ten open eye drops in use has not been dated when it was opened.

Corrective Action:

(i) Ensure medications are administered as prescribed. (ii) Ensure all eye drops are dated when they are opened.

Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA

Evidence:**Finding:****Corrective Action:**

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA

Evidence:**Finding:****Corrective Action:**

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: FA
Evidence: <p>The service has a large workable kitchen. The kitchen and the equipment are well maintained. The service employs a kitchen supervisor, two cooks and three kitchen hands to provide meal services over seven days a week. There is a rotating four weekly menu in place that was 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. A registered nurse completes each residents nutritional profile on admission with the aid of the resident and family. Special diets are catered for and documented in the kitchen</p> <p>Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented.</p> <p>The service encourages residents to express their likes and dislikes. The residents interviewed spoke highly about meals provided and they all stated that they are asked by staff about their food preferences. Equipment is available on an as needed basis. Residents requiring extra support to eat and drink are assisted, this was observed during lunch.</p> <p>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. Fridge/freezer temperatures are checked daily. Food in the fridge and chiller were covered and dated. The kitchen is clean and all food is stored off the floor. Chemicals are locked away.</p> <p>Food audits are carried out as per the yearly audit schedule.</p> <p>D19.2: Kitchen staff have been trained in safe food handling.</p>

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Attainment and Risk: PA Low
<p>Evidence:</p> <p>The building holds a current warrant of fitness which expires on 1 May 2014. Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted by an external fire safety contractor. When an issue requiring maintenance is noticed the facility manager contacts the maintenance person on the same day and in most cases the issue can be repaired or resolved on the same day. The maintenance person is available on an on call basis. External contractors are engaged to complete work as required. A sample of hot water temperatures are taken monthly and these are maintained at (or below) 45 degrees. The hoists are serviced annually and this last occurred in October 2013. All electrical equipment was last checked on 29 October 2013. Medical equipment has not been calibrated and this is an area requiring improvement.</p> <p>The facility's amenities, fixtures, equipment and furniture are appropriate for rest home and hospital residents. There is sufficient space to allow residents to move around the facility freely. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Resident's bedrooms throughout the facility have resident's own personal belongings displayed. External areas and garden areas surrounding the facility are well maintained. Level paths to the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained.</p> <p>ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, four hoists, heel protectors and lifting aids.</p>

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Low
Evidence: The building holds a current warrant of fitness, which expires on 1 May 2014. Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted by an external fire safety contractor. When an issue requiring maintenance is noticed the facility manager contacts the maintenance person on the same day and in most cases the issue can be repaired or resolved on the same day. The maintenance person is available on an on call basis. External contractors are engaged to complete work as required. A sample of hot water temperatures are taken monthly and these are maintained at (or below) 45 degrees. The hoists are serviced annually and this last occurred in October 2013. All electrical equipment was last checked on 29 October 2013.
Finding: Medical equipment has not been calibrated.
Corrective Action: Ensure medical equipment is calibrated according to manufacturer's instructions.
Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: 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 a restraint group at the facility where restraint is reviewed monthly. There are five residents with enablers in the form of bedsides, lap belts and bed bars. Bedsides are in use while the resident is in bed and two hourly monitoring is conducted while the bedsides are in position. These were requested by the residents. The restraint minimisation and safe practice policy outlines the process that staff should follow before enablers are implemented and includes identifying at risk behaviours, assessment procedures, alternatives and de-escalation techniques, discussion with multidisciplinary team, client and family/whanau, development of an

enabler care plan, monitoring, reduction, removal and evaluation of enablers.

The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of the file of the resident with an enabler, there are seven residents using restraint.

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA

Evidence:

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme – infection control surveillance audit was last undertaken in September 2013 (100% compliance). The service submits data monthly to Radius head office where benchmarking is completed. There were no corrective action requirements from the audit programme.

The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory and skin (link 1.2.3 regarding a corrective action programme relating to increased UTI rates). This data is reported to the quality meetings and also to staff

meetings. Monthly data was seen in staff areas.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*