

# Radius Residential Care Limited - Radius Windsor Court Rest Home

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Current Status: 14 April 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 Windsor Court is part of the Radius Residential Care Group. Windsor Court provides cares for residents requiring dementia and rest home level care. On the day of the audit there were 17 residents receiving dementia level care and 39 receiving rest home level care.

The facility manager has worked in health management roles since 1989 and has been a manager with Radius since 2001. She has been in the role for four years. A clinical nurse manager who has been in the position for one and a half years supports her. The Waikato operations manager and regional manager (both registered nurses) also support the facility manager. Families and residents spoke highly of the care provided at Windsor Court.

The three shortfalls identified at the previous audit have been addressed. These were around call bell placement, management of a resident with an allergy and aspects of medication management.

This audit has identified no further areas requiring improvement.

## Audit Summary as at 14 April 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 14 April 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 14 April 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 14 April 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.		Standards applicable to this service fully attained.
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#### Safe and Appropriate Environment as at 14 April 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.		Standards applicable to this service fully attained.
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#### Restraint Minimisation and Safe Practice as at 14 April 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 14 April 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)

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## 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

<b>Legal entity name:</b>	Radius Residential Care Limited		
<b>Certificate name:</b>	Radius Residential Care Limited - Radius Windsor Court Rest Home		
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited		
<b>Types of audit:</b>	Surveillance Audit		
<b>Premises audited:</b>	Radius Windsor Court Rest Home		
<b>Services audited:</b>	Rest home care and dementia care		
<b>Dates of audit:</b>	<b>Start date:</b> 14 April 2014	<b>End date:</b> 14 April 2014	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			56

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	7.5	<b>Hours off site</b>	5
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	7.5	<b>Total hours off site</b>	5
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	1

## Sample Totals

Total audit hours on site	15	Total audit hours off site	11	Total audit hours	26
Number of residents interviewed	5	Number of staff interviewed	9	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	3
Number of medication records reviewed	12	Total number of staff (headcount)	48	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	

## 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, 23 May 2014

## Executive Summary of Audit

### General Overview

Radius Windsor Court is part of the Radius Residential Care Group. Windsor Court provides cares for residents requiring dementia and rest home level care. On the day of the audit there were 17 residents receiving dementia level care and 39 receiving rest home level care. The facility manager has worked in health management roles since 1989 and has been a manager with Radius since 2001. She has been in the role for four years. A clinical nurse manager who has been in the position for one and a half years supports her. The Waikato operations manager and regional manager (both registered nurses) also support the facility manager. Families and residents spoke highly of the care provided at Windsor Court. The three shortfalls identified at the previous audit have been addressed. These were around call bell placement, management of a resident with an allergy and aspects of medication management. This audit has identified no further areas requiring improvement.

### 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 facility manager and staff keep them informed of their family member's status. Incident forms identify family is informed. 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 unsubstantiated complaint to the DHB around wound management.

### 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 Radius Windsor Court. 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 and other identified shortfalls. 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. The Windsor Court 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 provide evidence that the provider has systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified 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.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. The medications charts are easily read and all medications have been signed off by the GP. Designated staff are listed on the medication competency register, which shows signatures/initials to identify the administering staff member. There is a locked cupboard that is used for controlled drugs. During the medication round observed all practice was appropriate. The previous shortfalls around signing for medications given, ensuring all residents have a signed drug chart, and as required medications having timeframes have all been met.

The activities programme is facilitated by a diversional therapist and two assistants. The activities programme provides varied options and activities are enjoyed by the residents. Each resident has an individualised plan. Community activities are encouraged and 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 the menu plans have been reviewed by a dietician. Food and fridge temperatures 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. Call bells have been installed in the two rest home lounges and the rest home dining room and this is an improvement since the previous audit.

### **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. There are currently no residents using restraints or enablers. Staff have had training around restraint minimisation and the management of behaviours that challenge.

### **Outcome 3: Infection Prevention and Control**

There is a dedicated infection control coordinator (the clinical nurse manager) 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
<b>Standards</b>	0	17	0	0	0	0	0
<b>Criteria</b>	0	42	0	0	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	33
<b>Criteria</b>	0	0	0	0	0	0	0	59

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## 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 resident's 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 (from the rest home) stated they were welcomed on entry and were given time and explanation about services and procedures.

Fifteen incident reports were reviewed across the service. All recorded family notification. Four relatives interviewed (one from the rest home and three from the dementia unit) informed they are notified of any changes in their family member's health status. The clinical nurse 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 four 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. There is one resident with English as a second language at the service but she speaks excellent English and does not require an interpreter.

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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, and complaint forms or via suggestion box.

A client's 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 (from the rest home) and four relatives interviewed (one from the rest home and three from the dementia unit) 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 four complaints in 2014 to date. All have documentation of full investigation and resolution including communication with complainants is documented for all complaints. There was one unsubstantiated complaint relating to wound management through the DHB in February 2014.

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

E4.1biii: There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

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

## 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:**

Radius Windsor Court is part of the Radius Residential Care Group. Windsor Court cares for residents requiring dementia and rest home level care. On the day of the audit there were 17 residents receiving dementia level care and 39 receiving rest home level care. The facility manager has worked in health management roles since 1989 and has been a manager with Radius since 2001. She has been in the role for four years and has completed a New Zealand diploma in business, a small business diploma and a diploma in human resources. A clinical nurse manager who has been in the position for one and a half supports her. The Waikato operations manager and regional manager (both registered nurses) also support the facility manager. The facility manager reports monthly to the regional manager on a range of operational matters in relation to Windsor Court including strategic and operational issues, incidents and accidents, complaints, health and safety. The Radius mission statement states that:  
"We deliver a quality lifestyle with an innovative approach to care that enables us to maintain the wellbeing, dignity and independence of our residents"  
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 Windsor Court has developed site-specific objectives including:

1. Clinical and Operational key performance indicators
2. 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 monthly regional manager meetings and a full conference in 2013.

E2.1: The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

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

#### **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:**

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

### **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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>There are organisational policies to guide each facility to implement the quality management programme including (but not limited to); continuous quality improvement programme policy, continuous quality improvement methodology policy, quality indicator data collection policy and internal audit timetable.</p> <p>There is evidence that the quality system continues to be implemented at Windsor Court. 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 dementia unit and four who work in the rest home) and the clinical nurse manager confirmed that quality data is discussed at monthly staff meetings (staff meeting minutes reviewed). The facility manager advised that she is responsible for providing oversight of the quality programme. There is also a monthly staff meeting where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff who cannot attend.</p> <p>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. Assessment tools completed linked with resident care plans and were reviewed six monthly. There is an annual staff-training programme that is implemented and based around policies and procedures. Internal audits are completed for care delivery compliance, care plans compliance, clinical records, medications, hand washing, privacy.</p> <p>D5.4 The service has the appropriate policies and procedures to support service delivery;</p> <p>There are policies and procedures appropriate for service delivery. 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). Staff have access to manuals (nurse's stations and staff room). Policies are up to date and are located electronically on 'P' drive.</p> <p>Monthly reports by the facility manager to the regional manager are provided on service indicators. The staff meetings are minuted and with a set agenda including (but not limited to): health &amp; safety, incident and accidents, complaints/compliments. Information is taken to staff through the various meetings, staff notice boards.</p> <p>a) There are monthly accident/incident reports completed by the facility manager that break down the data collected across the service.</p> <p>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.</p> <p>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</p>

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 staff meetings, feedback is provided to staff and RN meetings. There are currently no restraints or enablers being used at Windsor Court.

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 Windsor Court by the facility manager. The audit programme includes (but not limited to); care plans, care delivery compliance, health and safety, IC, medications, code of rights, informed consent, vehicle compliance and restraint. Quality improvement data such as incidents /accidents, hazards, internal audit, infections are collected and analysed/evaluated at the staff meeting.

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. Corrective action plans are developed for audits with outcomes below 95% and also for significant incidents or complaints at Windsor Court.

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 and this has occurred at Windsor Court. Radius has 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

### **Standard 1.2.4: 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, and fractures), skin tears, medication and pressure areas.

When an incident occurs the healthcare assistant (or staff discovering the incident) completes the form and will undertake an initial assessment. The registered nurse (if on duty) or senior healthcare assistant will notify family and GP as required. The clinical nurse manager collects incident reports daily and reviews both the incident and actions taken. Where the action taken is not considered to have been comprehensive, the clinical nurse manager will investigate and escalate to the facility manager. Fifteen incident forms sampled evidence detailed investigations and corrective action plans following incidents including neuro observations for three residents who had hit their head.

Monthly data is taken to the risk management and restraint meeting. The five healthcare assistants 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.

D19.3c Discussions with the 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 is sighted) and outcomes are discussed at all staff meetings.

Fifteen incident forms were reviewed across the service and clinical actions were well documented. Actions taken to minimise risk to individual residents are recorded.

**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.

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

**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.

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

## 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 and podiatrist.

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

The organisation has a staff orientation policy. Windsor Court 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 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 Windsor Court to embed information from the sessions provided. Challenging behaviour and dementia are part of the training programme.

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 and medication.

E4.5d: The orientation programme is relevant to the dementia unit and includes a session on how to implement activities and therapies.

E4.5f: There are eight healthcare assistants who work in the dementia unit. Four have completed the required dementia standards and the other four healthcare assistants are in the process of completing and have not yet been at the service for six months.

### 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:**

<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>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 work full time. There is a second full time registered nurse and between the clinical nurse manager and the second RN there is an RN on duty seven days per week. A third RN works eight hours per week, mainly in an ACE education role but also provides RN support around care planning. There is an RN on call 24/7.</p> <p>Staff turnover is reducing following a period of moderate turnover when several staff went on maternity leave and did not return or retired. The five healthcare assistants (one who works in the dementia unit and four who work in the rest home and all who work mornings, afternoons and nights) report adequate staffing.</p> <p>Five residents (from the rest home) and four relatives (one from the rest home and three from the dementia unit) interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent and friendly.</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

## 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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>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 or activities coordinator.</p> <p>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) 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 needs. The care summary is reviewed as part of the regular resident review process (six monthly or sooner if needs change). Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery.</p> <p>All five files identified integration of allied health including district nurses, oncology, DHB nurse specialist, physiotherapy and podiatry. The GP was unavailable for interview on the audit day.</p> <p>D16.2, 3, and 4: The five resident files reviewed (two from the rest home, three from dementia), identified that in all five files a nursing assessment was completed within 24 hours and four of five files identify that the long-term care plan was completed within three weeks. One file was a resident in for respite care. There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. Three of five care plans reviewed evidenced evaluations completed at least six monthly. One resident had been in the facility less than six months and one resident was admitted for respite care.  D16.5e: Four of five files (one resident was in for respite) sampled identified that the GP had seen the resident within two working days. It was noted in four of five files sampled that the GP had examined the resident and deemed them stable and for three monthly review.</p>

Tracer Methodology:

Rest home:

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

Tracer methodology: Dementia:

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

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

**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):** (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:** FA

**Evidence:**

The service provides services for residents requiring rest home, and dementia care. Care plans are completed comprehensively. Five residents files (two from the rest home, three from dementia), were reviewed for this audit:

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

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

Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management, plans are evident. Three care plans evidenced at least six monthly care plan reviews. One was not due and one resident in for respite care. The use of short-term care plans is evident. 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 dementia levels of care, four family members (one from the rest home, three from dementia), the clinical nurse manager (RN), the Waikato operations manager and the facility manager. Residents' needs are assessed prior to admission and resident's primary care is provided by the GP.

There is evidence of referrals to specialist services such as podiatry, physiotherapy, district nurses, nurse practitioner and 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 12 residents with wounds and one resident with two pressure areas. On interview, the clinical nurse 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. The service has booked wound care training for July, which will focus on skin tears. Skin tear prevention and skin cares are discussed at handover and at staff meetings. The previous audit identified a need for education around allergic reactions and the use of the epi-pen. There is evidence that education has been completed. The previous shortfall has been met.

**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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The diversional therapist employed by the service has worked at Windsor Court for two years and works 37.5 hours over five days. She completed her diversional therapy training in August 2013. The activities coordinator has worked at Windsor Court for two years and works 30 hours over five 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 dementia lounge and the rest home activities room. 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</p>

entertainers, crafts, exercise, music/sing-alongs, bingo movies and outings. There are also visits from community groups. All four family members (one from the rest home, three from dementia) interviewed stated that activities are appropriate and varied enough for the residents. All five residents (from the rest home), interviewed stated they were happy with the activities available and are given a choice regarding attendance. D16.5d: Three resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed. Two resident files 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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>All initial care plans were developed by an RN 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 three of five care plans reviewed. One was not due for evaluation and one resident was in for respite care. Changes in health status are documented and followed up. Care plan reviews are signed as completed by an RN. 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.  D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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:** FA

**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 an RN. 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. 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 ten medication charts had allergies (or nil known), documented. The service documents adverse reactions and errors on incident/accident forms. There is a locked cupboard that is used for controlled drugs. There are drug trolleys that are kept in the medication rooms (one for rest home, one for dementia) which are locked when not in use. Medication round observed; all practice is appropriate. Medication charts are in place appropriately signed by the GP including timeframes for prn medication. 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. The previous shortfalls around signing for medications given, ensuring all residents have a signed drug chart, and prn medications having timeframes have all been met. 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:** 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 1.3.12.3 (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.

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

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

**Finding:**

**Corrective Action:**

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

### **Standard 1.3.13: 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:**

The service has a workable kitchen. Plans are in place for a kitchen upgrade. The service employs 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. An RN completes each resident's nutritional profile on admission with the aid of the resident and family. Special diets are catered for and documented in the kitchen.

Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented.

The 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.

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.

Food audits are carried out as per the yearly audit schedule.

E3.3f, there is evidence that there are additional nutritious snacks being available over 24 hours.

D19.2: Kitchen staff have been trained in safe food handling.

### **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:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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:** FA

**Evidence:**

The building holds a current warrant of fitness, which expires on 17 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. All electrical equipment was last checked on 25 February 2013. Medical equipment was calibrated on 2 July 2013.

The facility's amenities, fixtures, equipment and furniture are appropriate for rest home and dementia level residents. There is sufficient space to allow residents to move around the facility freely. The hallways have handrails 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.

D15.3: The following equipment is available: shower chairs and lifting aids.

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities.

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c: There is a safe and secure outside area that is easy to access.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

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

**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.

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

**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.

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

## Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

**Attainment and Risk:** FA

**Evidence:**

The previous audit identified that there were no call bells in two lounges and one dining room in the rest home. Call bells have been installed in these areas and there are now call bells available in all areas of the facility. The previous shortfall has been addressed.

### Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when 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.)*

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

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## 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 restraint minimisation and safe practice policy & procedure includes; a) definitions, b) Use of restraint is a last resort only, c) methods of restraint permitted within Radius, d) use of enablers, e) enablers permitted with radius, f) client rights, g) assessment, discussion & restraint alternatives, h) restraint alternatives are not effective, i) restraint care, j) monitoring and removal, k) restraint episode evaluation, l) risks associated with restraint, m) restraint coordinator, n) staff training, o) restraint meetings, and p) maintenance.

Related forms include: restraint assessment, discussion and alternatives form; restraint discussion and consent form; restraint monitoring form; enabler assessment and consent form; restraint register; enabler register; care plan for client requiring restraint; restraint episode evaluation form.

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 restraint minimisation is discussed at monthly staff meetings at Windsor Court.

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. There are no enablers or restraints in use at Windsor Court.

E4.4a The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.

### 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

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## 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 March 2014 (98% 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. 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.

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