

Radius Residential Care Limited - Radius Fulton Care Centre

Current Status: 26 May 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 Fulton Care is part of the Radius Residential Care Group. Fulton Care cares for up to 93 residents requiring hospital, rest home and dementia level care. On the day of the audit there were 50 residents receiving hospital level care, 23 receiving rest home level care and 17 receiving dementia level care. This audit also assessed six new single rooms as able to be used for either hospital or rest home level care.

The facility manager has 18 years aged care experience and has been at the facility as manager for 12 years. An experienced clinical manager, who has been in the position for five years, supports her. The clinical manager is leaving and the new clinical manager who is orientating has a strong aged care background including clinical manager and manager roles. The regional manager (a registered nurse) also supports the facility manager. Families and residents spoke highly of the care provided at Fulton Care.

All of the five shortfalls identified at the previous audit have been addressed. These were around quality data reporting, care planning, aspects of medication documentation, call bells and infection surveillance.

This audit has identified further improvements required around completing neurological observations following a head injury.

Audit Summary as at 26 May 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

Indicator	Description	Definition
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 26 May 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.
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

Organisational Management as at 26 May 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.		Some standards applicable to this service partially attained and of low risk.
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-------------------------------------------------------------------------------

Continuum of Service Delivery as at 26 May 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.
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

Safe and Appropriate Environment as at 26 May 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.
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

Restraint Minimisation and Safe Practice as at 26 May 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.
---------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

Infection Prevention and Control as at 26 May 2014

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

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 Fulton Care Centre		
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Radius Fulton Care Centre		
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care and dementia care		
Dates of audit:	Start date: 26 May 2014	End date: 27 May 2014	
Proposed changes to current services (if any):			
	This audit has approved six new single rooms to be used for either hospital or rest home level care.		
Total beds occupied across all premises included in the audit on the first day of the audit:			90

Audit Team

Lead Auditor	XXXXX	Hours on site	12	Hours off site	6
Other Auditors	XXXXX	Total hours on site	12	Total hours off site	5
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	24	Total audit hours off site	13	Total audit hours	37
Number of residents interviewed	7	Number of staff interviewed	13	Number of managers interviewed	3
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	4
Number of medication records reviewed	12	Total number of staff (headcount)	80	Number of relatives interviewed	8
Number of residents' records reviewed using tracer methodology	3			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 Thursday, 19 June 2014

Executive Summary of Audit

General Overview

Radius Fulton Care is part of the Radius Residential Care Group. Fulton Care cares for residents requiring hospital, rest home and dementia level care for up to 93 residents. On the day of the audit there were 50 residents receiving hospital level care, 23 receiving rest home level care and 17 receiving dementia level care. This audit also assessed six new single rooms as able to be used for either hospital or rest home level care.

The facility manager has 18 years aged care experience and has been at the facility as manager for 12 years. An experienced clinical manager who has been in the position for five years supports her. The clinical manager is leaving and the new clinical manager orientating has a strong aged care background including clinical manager and manager roles. The regional manager (a registered nurse) also supports the facility manager. Families and residents spoke highly of the care provided at Fulton Care.

All of the five shortfalls identified at the previous audit have been addressed. These were around quality data reporting, care planning, aspects of medication documentation, call bells and infection surveillance.

This audit has identified further improvements required around completing neurological observations following a head injury.

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 have been no recent external complaints.

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 Fulton Care.

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 quality improvement initiatives to improve outcomes for residents.

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. There is an improvement required around completing neurological observations following a knock to the head.

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

Fulton Care 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 and is sufficient to cater for the extra six hospital residents.

Outcome 1.3: Continuum of Service Delivery

Care plans are developed in consultation with relevant people including residents and where appropriate family / whanau or Enduring Power of Attorney. An initial nursing assessment, including a variety of risk assessments are completed on admission and risk assessments are reviewed six monthly following admission. Residents and/or family have input into the development of care plans. Communication with family is well documented. All residents have an individualised care plan that reflects current needs. These are reviewed six monthly and updated as needs change. Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity care plans included in the long term care plan identify goals, and interventions and are evaluated at least six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly. An appropriate medicine management system is implemented. Policies and procedures detail service provider's responsibilities. Registered nurses administer medications in the rest home and hospital and registered nurses, enrolled nurses or senior caregivers administer medications in the dementia unit. Staff responsible for medicine management have attended in-service education for medication management and complete a medication competency annually. Medication charts sighted evidence documentation of residents' allergies/sensitivities and three monthly medication reviews completed by general practitioners. Residents that self-administer have three monthly competency assessments. A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site by an external contractor. All kitchen assistants employed by the service have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services.

Outcome 1.4: Safe and Appropriate Environment

The facility building warrant of fitness was sighted and is current. Preventative and reactive maintenance occurs. The call bell system has been updated since the previous audit and call bells in all areas of the service alert staff via a telephone carried by every staff member. This audit has approved six new single rooms to be used for either hospital or rest home level care. The six rooms are large enough to cater for the required care staff and equipment for hospital level residents. There is a large disabled bathroom in the wing to cater for the six rooms and lounges are large enough to cater for the extra equipment such as fall out chairs and lazy boy chairs required for hospital level residents.

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 nine residents using restraint and nine residents using enablers. Enabler use is voluntary. All staff have had on-going training around restraint minimisation and the management of behaviours that challenge.

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 and includes all infections including those not requiring antibiotics.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	16	0	1	0	0	0
Criteria	0	41	0	1	0	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 1.2.4: Adverse Event Reporting	All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	Neurological observations were not completed for two of three residents who had hit their head.	Ensure neurological observations are completed for head injuries.	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 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. Seven residents (three from the rest home and four from the hospital) stated they were welcomed on entry and were given time and explanation about services and procedures.

Thirteen incident reports were reviewed across the service. All recorded family notification. Eight relatives interviewed (one from the rest home, four from the dementia unit and three from the hospital) informed they are notified of any changes in their family member's 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 eight 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 are two residents who do not speak English and both residents have family members who translate for them.

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, 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 seven residents (three from the rest home and four from the hospital) and eight relatives interviewed (one from the rest home, four from the dementia unit and three 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 three complaints in 2013 and three in 2014 to date. All have documentation of full investigation and resolution including communication with complainants is documented for all complaints.

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 Fulton Care is part of the Radius Residential Care Group. Fulton Care cares for residents requiring hospital, rest home and dementia level care for up to 93 residents. On the day of the audit there were 50 residents receiving hospital level care, 23 receiving rest home level care and 17 receiving dementia level care. This audit also assessed the appropriateness of six new single rooms as able to be used for either hospital or rest home level care. These rooms are already being used for hospital level care following permission to do so from HealthCERT.

The facility manager has 18 years aged care experience and has been at the facility as manager for 12 years. An experienced clinical manager who has been in the position for five years supports her. The clinical manager is leaving and the new clinical manager orientating has a strong aged care background including clinical manager and manager roles. The regional manager (a registered nurse) also supports the facility manager. The facility manager reports monthly to the regional manager on a range of operational matters in relation to Fulton Care including strategic and operational issues, incidents and accidents, complaints, health and safety. 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 Fulton Care 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 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.

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 mini conferences, a full Radius managers conference in 2013 and several DHB trainings in the last year.

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:
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 Fulton Care.

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. There is evidence that the quality system continues to be implemented at Fulton Care. Staff have designated portfolios including incidents and accidents, training, restraint, health and safety and infection control. Interviews with seven healthcare assistants (three who work in the hospital, two who work in the rest home, one who works in the dementia unit and one who works in the rest home and dementia unit), one enrolled nurse and one registered nurse confirmed that quality data is discussed at monthly staff meetings (staff and registered nurse (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. 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.

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. A review of incident data demonstrates that the facility data correlates with that reported to Radius head office for benchmarking and this is an improvement since the previous audit.
- 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 Fulton Care 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 quality meeting and staff are informed through the registered nurses and staff meetings. Minutes of RN meetings verified audit results are discussed.

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. There have also been a number of quality improvement initiatives implemented including:

1. November 2013 – eliminate avoidable medication errors
2. December 2013 – reduce skin tears to below the Radius average
3. January 2014 – reduce avoidable falls by 50%
4. March 2014 – educate RN;s and develop effective behaviour management plans for residents with behaviours that challenge
5. Reduce the use of antipsychotic medication

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 been done at Fulton Care. 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <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.

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 1.2.3.8 (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: PA Low

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 the registered nurse will undertake an initial assessment. The registered nurse will notify family and GP as required. The clinical manager collects incident reports daily and review both the incident and actions taken. Where the action taken is not considered to have been comprehensive, the clinical nurse leader will investigate and escalate to the facility manager. Thirteen incident reports sampled evidence detailed investigations and corrective action plans following incidents. However, neurological observations were not completed for two of three residents who had hit their head. This is an area requiring improvement.

Monthly data is taken to the risk management and restraint meeting. The seven healthcare assistants, one enrolled nurse and one registered nurse 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 service (facility manager) confirms an awareness of the requirement to notify relevant authorities (DHB) in relation to essential notifications. Public Health, the DHB and HealthCERT were informed promptly of a gastrointestinal outbreak in May 2014.

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.

Thirteen incident reports 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.

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: PA Low

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 the registered nurse will undertake an initial assessment. The registered nurse will notify family and GP as required. The clinical manager collects incident reports daily and review both the incident and actions taken. Where the action taken is not considered to have been comprehensive, the clinical nurse leader will investigate and escalate to the facility manager. Thirteen incident reports sampled evidence detailed investigations and corrective action plans following incidents.

Finding:

Neurological observations were not completed for two of three residents who had hit their head.

Corrective Action:

Ensure neurological observations are completed for head injuries.

Timeframe (days): 90 (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 six 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 dietitian.

Recruitment, selection and appointment of staff policy is in place. Six staff files were reviewed (one activities coordinator, the clinical manager, one registered nurse and three health care assistants) and all have a current performance appraisal.

The organisation has a staff orientation policy. Fulton Care 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 seven healthcare assistants, one enrolled nurse and one registered nurse informed there is an orientation process provided that included a period of being buddied.

In all six 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. Challenging behaviour and dementia are part of the training programme. The service has introduced toolbox talks where registered nurses provide a short education session to staff at handover when an issue is identified. Examples include hydration and use of continence products.

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.

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

E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.

E4.5f There are 10 caregivers who work in the dementia unit and they have all completed the required dementia standards.

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

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 manager (a registered nurse) work full time. Additionally there are three registered nurses on morning shift, two on afternoon shift and one overnight. The facility has an arrangement with the four wheel drive club to transport staff to work when the area is snow bound.

Staff turnover is low. The seven healthcare assistants (three who work in the hospital, two who work in the rest home, one who works in the dementia unit and one who works in the rest home and dementia unit and all who work mornings, afternoons and nights), one enrolled nurse and one registered nurse interviewed stated that there is adequate staffing to manage their workload on any shift. Staffing is sufficient to cover the six extra hospital level residents two are currently in the six rooms being approved for either rest home or hospital level use at this audit.

The GP was interviewed and confirmed that staffing is appropriate to meet the needs of residents.

Seven residents (three from the rest home and four from the hospital) and eight relatives interviewed (one from the rest home, four from the dementia unit and three 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; D16.5ci; 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 activities coordinator in the rest home and hospital and the diversional therapist in the dementia unit.

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.

All six files (two from the hospital, two from the rest home and two from dementia) identified integration of allied health including district nurses, nurse practitioners, mental health services, 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 six resident files reviewed (two from the hospital, two from the rest home and two from dementia), identified that in all six files a nursing assessment was completed within 24 hours and six of six 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 RN and amended when current health changes. Four of six care plans reviewed evidenced evaluations completed at least six monthly. Two residents had been in the facility less than six months.

Tracer Methodology Hospital;

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

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): <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 1.3.6: 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
<p>Evidence:</p> <p>The service provides services for residents requiring rest home, hospital level care and dementia care. Care plans are completed comprehensively. Six resident files (two from the hospital, two from the rest home and two from dementia) were reviewed for this audit.</p> <p>Rest home; one resident with dementia and challenging behaviours and one resident with frequent falls.</p> <p>Hospital; one resident with cerebral vascular accident and one resident receiving palliative care</p> <p>Dementia; one resident with frequent falls and one resident admitted for respite care.</p> <p>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 are evident. The care being provided is consistent with the needs of residents, this is evidenced by discussions with seven health care assistants who work both am and pm shifts and who work across rest home, hospital and dementia levels of care, eight family members (one from the rest home, three from the hospital and four from dementia), one RN, one enrolled nurse, two clinical managers (RNs) 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.</p> <p>There is evidence of referrals to specialist services such as podiatry, physiotherapy, district nurses, hospice, psychogeriatric nurses, gerontology nurse specialist and NASC. There is also evidence of community contact.</p> <p>D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.</p> <p>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.</p> <p>Specialist continence advice is available as needed and this could be described.</p> <p>Continence management in-services (June 2013 35 staff attended) and wound management (July 2013 12 RNs attended) in-service have been provided. Wound assessment and wound management plans are in place for eight residents with wounds (three ulcers, one lesion and one skin tear from the rest home/dementia and three skin tears from the hospital). Six residents have grade 1 pressure areas (one from the rest home and one from the hospital). On interview the one RN and the two clinical managers 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.</p>

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: 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 1.3.7: 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: <p>There are two activities coordinators and two diversional therapists employed by the service. Both activities coordinators are responsible for planning and delivery of the combined programme in the rest home and hospital. One of the activities coordinators has been employed for many years and she works 35 hours per week. The other activities coordinator works 25 hours per week. Both diversional therapists have been qualified since 2001 and have worked at the service prior to qualification. The diversional therapists are employed to work in the dementia unit and work on a roster including weekends 10am -7pm. They are responsible for planning and delivery of the activity programme in the dementia unit.</p> <p>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 and dementia 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. The activities staff have attended training sessions with the Dunedin diversional therapy group.</p> <p>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 including shows in Dunedin and Opportunity shows. The service has its own van and contracts the service of a driver to accompany the activity staff. There are also visits from community groups including school children. Church services are provided. The activities coordinators and residents of the service present/host a fortnightly radio programme on community radio that is listened to by members of the public. This allows residents to play an active part in their community and one of the two rest home residents who is involved in the radio hosting reports that he receives feedback from members of the community that the programme gives the community a positive view of aging and challenges the public's perceptions of life in an aged care facility. The two rest home residents interviewed who are involved in the radio programme report that it keeps them 'young' and their minds active.</p> <p>In the weeks leading up to Anzac day the activity coordinator supported residents to make a movie of residents describing their experiences of Anzac days past, both during the war and after it. The movie has been edited and presents the residents talking about their memories. The movie was played at the Anzac day service and provided to all family members who had a resident in the movie. The family member interviewed who had a resident in the movie described the movie as a treasure that will provide joy to her family for generations to come</p> <p>All eight family members (one from the rest home, three from the hospital and four from dementia), interviewed stated that activities are appropriate and varied enough for</p>

the residents. All seven residents (three from the rest home and four from the hospital), interviewed stated they were happy with the activities available and are given a choice regarding attendance.
 All activity staff have a current first aid certificate.
 The activity programme is adequate to accommodate adequate an extra six beds to be used for either rest home or hospital level residents as required.
 D16.5d: Four resident files reviewed identified that the individual activity plan is reviewed when at care plan review. 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.

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 1.3.8: 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: <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 four of six care plans reviewed, two residents had not been at the facility for longer than six months. Overall 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.

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: 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 12 medication charts had allergies (or nil known), documented. All PRNs have documented indication for use by the GP. All eye drops in use have a date of opening sighted. The service documents adverse reactions and errors on incident/accident forms. There are two locked cupboards that are used for controlled drugs. Two signatures were evident for all controlled drugs. Weekly and six monthly checks were evident. There are drug trolleys that are kept in the nurses' stations which are locked when not in use. Medication round observed in four areas; 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 is currently one resident who self-administer medication and six residents that self-administer inhalers only. All seven residents have current three monthly competency assessments. D16.5.e.i.2: Twelve 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): (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 contracts food services to an external contractor who leases the kitchen within the service. There is a large workable commercial kitchen which has current grade A approval from the city council and expires in February 2015. The kitchen and the equipment are well maintained. The external contractor provides all meal services over seven days a week and is responsible for food purchasing and also provides food for a number of external customers including other aged care facilities. The kitchen is adequate to accommodate an extra six beds to be used for either rest home of hospital level residents as required. There is a rotating four weekly menu in place that has been approved by a dietitian and to be reviewed in 2015. 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 including mouli, puree, soft, gluten free and those residents with food allergies. Food safety information and a kitchen manual are available in the kitchen. The service employs seven kitchen assistants to serve the food prepared by the external contractor. Food served on the day of audit was hot and well presented. Food is served directly from bain maries in two serveries. Meals for hospital residents that require assistance is kept hot in hot boxes and covered. The service encourages residents to express their likes and dislikes and this is documented on a form for daily serving. 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 external contractor 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. The contractor checks food temps prior to leaving the kitchen and the kitchen assistants check the food temps prior to serving the hot meal. 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. All kitchen assistants have completed food safety training. E3.3f: there is evidence that there is additional nutritious snacks available over 24 hours.

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

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: FA

Evidence:

The building holds a current warrant of fitness which expires on 3 March 2015. 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. 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 7 October 2013. Medical equipment was last calibrated in November 2013.

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.

This audit has approved six new single rooms to be used for either hospital or rest home level care. The six rooms are large enough to cater for the required care staff and equipment for hospital level residents. There is a large disabled bathroom in the wing to cater for the six rooms and lounges are large enough to cater for the extra equipment such as fall out chairs and lazy boy chairs required for hospital level residents.

ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, sling and standing hoists, heel protectors and lifting aids.

E3.4d: The dementia unit 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:

Finding:

Corrective Action:

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

Criterion 1.4.2.4 (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): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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 the call bell system in one six bed wing was unsatisfactory. The system has been upgraded and now all rooms in the facility have a call bell which rings directly to the telephone system. Every staff member (including the clinical manager) carries a telephone and when the bell is rung the telephone shows which room the bell is ringing in. The person answering the bell can then have direct voice contact with the person ringing the bell through a speaker phone in each residents room while the staff member is making their way to the room. Bells rung during the audit were noted to be answered promptly and residents and family interviewed report bells are answered promptly. 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

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:

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 a restraint group at the facility where restraint is reviewed.

There are nine residents with enablers in the form of bedsides and lap belts. These were requested by the residents as evidenced in the two files sampled of residents with enablers.

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 nine residents using restraint and this number is gradually reducing.

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

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. All infections including those not requiring prescribed treatment are included in the infection surveillance data and this is an improvement since the previous audit. 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>