# Radius Residential Care Limited - Radius Windsor Court Rest Home

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Radius Residential Care Limited

**Premises audited:** Radius Windsor Court Rest Home

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 1 July 2015 End date: 2 July 2015

**Proposed changes to current services (if any):** The service is adding hospital level care to their current certification. This audit has assessed the service as able to use 20 previously rest home only beds for either rest home or hospital level residents.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 47

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Windsor Court Rest Home is owned and operated by Radius Residential Care Limited and currently cares for up to 61 residents requiring rest home or dementia level care. On the day of the audit there were 47 residents. The manager is well qualified and experienced for the role and is supported by a clinical nurse manager and the regional manager.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident’s and staff files, observations and interviews with residents, relatives, staff and management.

A partial provisional was also completed as part of this audit to assess the service suitability to provide hospital level care in 20 previously rest home only rooms. These rooms have been assessed as suitable to provide hospital level care (dual purpose).

Residents, relatives and the GP interviewed spoke positively about the service provided.

This audit has identified areas for improvement around aspects of medication management and documentation of time in progress notes. Prior to the admission of hospital level residents one bathroom requires alterations and sufficient registered nurses need to be employed.

The service has exceeded the required standard around business goal planning and review, leadership training for the manager, the falls project, providing a safer environment using scanners and white noise, introduction of a men’s group, infection prevention and control links with other organisations and response to data analysis and improvements to the dementia unit external areas.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Staff at Windsor Court strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights. Cultural needs of residents are met. Policies are implemented to support residents’ rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

The facility manager is qualified and experienced for the role and she is supported by an organisational team, a clinical nurse manager, a registered nurse and care staff. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities, including Radius key performance indicators, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings have been held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Discussions with families identified that they are fully informed of changes in health status. A comprehensive education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and a draft roster to manager the change to hospital level care.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The service has a well-developed assessment process and resident’s needs are assessed prior to entry. Assessments, care plans and evaluations are completed by the registered nurses. Residents/relatives are involved in planning and evaluating care. Risk assessment tools and monitoring forms are available and implemented and are used to assess the level of risk and support required for residents. Service delivery plans demonstrate service integration. Short term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services.

The activities team provide an activities programme that involves the wider community. Each resident has an individualised plan and activities are scheduled across the week.

The service medication management system follows recognised standards and guidelines for safe medicine management practice. Controlled medication balances are checked weekly. Staff complete competency assessments.

Meals are prepared on site, Individual and special dietary needs are catered for. Residents interviewed responded favourably about the food that was provided.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of low risk. |

Chemical safety is maintained. The rooms in the proposed hospital wing and lounges and dining area in this wing are suitable for providing hospital level care. There is adequate equipment provided to ensure the needs of residents are met and suitable equipment to provide hospital level care has been ordered. The building holds a current warrant of fitness. A maintenance prevention programme is implemented. Electrical equipment is checked annually. There are a number of communal lounges and dining areas. There are documented laundry services policies/procedures. There is a plentiful supply of protective equipment, gloves, and aprons. Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan. The facility has civil defence kits and emergency management plans.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Windsor Court has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were no residents with restraint and no residents with an enabler.

## Infection prevention and control

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| --- | --- | --- |
| 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 3 | 38 | 0 | 3 | 1 | 0 | 0 |
| **Criteria** | 9 | 80 | 0 | 3 | 1 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (four healthcare assistants (HCA’s) – two from the dementia unit and two from the rest home, one registered nurse, the administrator, the diversional therapist, the facility manager and the clinical nurse manager) confirm their familiarity with the Code. Interviews with seven residents (from the rest home) and six relatives (three rest home and three from the dementia unit) confirm the services being provided are in line with the Code. Code of rights and advocacy training has been provided. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their EPOA. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Health care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives.  Seven of seven resident files sampled (four from the rest home and three from the dementia unit) have a signed admission agreements and consents. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents’ meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Interviews with residents and relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident’s life are documented in the care plans. Discussions with residents and relatives verify that they are supported and encouraged to remain involved in the community. Staff at Windsor Court support on-going access to community. Entertainers are invited to perform at the facility. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | A complaints policy and procedure is in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint’s forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception. A review of the complaints register evidences that the appropriate actions have been taken in the management and processing of complaints. A complaints procedure is provided to residents within the information pack at entry.  There is written information on the service philosophy and practices particular to the dementia unit included in the information pack. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Information is provided to residents and family members of Radius Windsor Court that includes the Code, complaints and advocacy information. Residents and relatives confirmed this on interview. The facility manager, clinical nurse manager and registered nurse provide an open-door policy for concerns or complaints. Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. Resident meetings have been held providing the opportunity to raise concerns in a group setting. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Church services are held weekly and there is a monthly interdenominational service. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirm the service is respectful and that they are given the right to make choices. Care plans reviewed identified specific individual likes and dislikes. Staff education and training on abuse and neglect has been provided. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There is a Radius Maori heath plan and an individual’s values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. Residents who identify as Maori have this included in their care plan. There is information and websites provided within the Maori health plan to provide quick reference and links with local Maori. Interviews with staff confirm they are aware of the need to respond appropriately to maintain cultural safety. Cultural safety training has been provided. There were six Maori residents at Windsor Court at the time of the audit and cultural needs were addressed in care plans reviewed. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed. Family involvement is encouraged e.g. invitations to residents meetings and facility functions. Care plans reviewed included the residents’ social, spiritual, cultural and recreational needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with staff and management. Interviews with staff confirm their understanding of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The Radius quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Policies and procedures have been reviewed and updated at organisational level and are available to staff. Staff meetings and residents meetings have been conducted. Residents and relatives interviewed spoke very positively about the care and support provided. Staff had a sound understanding of principles of aged care and state that they feel supported by the facility manager and nursing staff. There are implemented competencies for health care assistants and registered nurse. There are clear ethical and professional standards and boundaries within job descriptions. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. A sample of incident reports reviewed, and associated resident files evidenced recording of family notification. Relatives interviewed confirm they are notified of any changes in their family member’s health status. The acting facility manager and registered nurses were able to identify the processes that are in place to support family being kept informed. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.  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. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | CI | Windsor Court is part of the Radius Residential Care group. The service currently provides rest home and dementia level care for up to 61 residents. On the day of the audit there were 32 rest home and 15 dementia level residents. This includes two residents on short term respite care and one in the dementia unit on a long term chronic health needs contract. This audit has also assessed the service as able to provide hospital level care in 20 rooms that were previously for rest home level residents.  The facility manager is well trained and experienced and has been in the role for five years. She is supported by a competent clinical nurse manager and the Radius regional manager. The clinical nurse manager is responsible for the oversight of registered nurses and clinical care. This is reflected in the job description. Radius has an overall business/strategic plan and Windsor Court has a facility quality and risk management programme in place for the current year. The business plan includes business goals including the development of the service to provide hospital level care. Progress toward goals is regularly reported. The organisation has a philosophy of care which includes a mission statement. The facility manager has completed in excess of eight hours of professional development in the past 12 months.  The service has exceeded the standard around the identification of the scope, direction and goals of the service and regular review of these goals and the training of the manager and benefits of this to the staff, residents and families. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the facility manager, the clinical nurse manager is in charge with support from the regional manager, the registered nurse, the administrator and care staff. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is an organisational business plan that includes quality goals and risk management plans for Windsor Court. There is evidence that the quality system continues to be implemented at Windsor Court. Interviews with staff confirmed that quality data is discussed at monthly staff meetings. The facility manager advised that she is responsible for providing oversight of the quality programme. There is a monthly staff meeting where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff. 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. New/updated policies are sent from head office. Staff have access to manuals. A weekly report is provided to the regional manager and monthly data is collated in relation to Radius key performance indicators (KPI).  Resident/relative meetings are held. Restraint and enabler use is reported within the quality management meetings.  Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. There is a death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.  The service has exceeded the standard around the analysis of quality data and the use of this data to improve resident outcomes. |
| 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. | FA | There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the clinical nurse manager and analysis of incident trends occurs. Incidents are included in the Radius KPI’s. There is a discussion of incidents/accidents at monthly staff meetings including actions to minimise recurrence. Clinical follow up of residents is conducted by a registered nurse as confirmed on 10 incident reports sampled. Discussions with the facility manager and regional manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resource management policies in place which includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Seven staff files were reviewed and evidence that reference checks are completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is relevant to the dementia unit and includes a session on how to implement activities and therapies. The in-service education programme for 2014 has been completed and a plan for 2015 is being implemented. Healthcare assistants have completed an aged care education programme and all have completed hoist and manual handling in preparation for providing hospital level care. The clinical nurse and registered nurse are able to attend external training including sessions provided by the local DHB. Annual staff appraisals were evident in all staff files reviewed. Six monthly fire evacuation drills have been conducted.  There are 10 caregivers who work in the dementia unit. Three have completed the ACE dementia NZQA standards and the other seven are all enrolled and have not yet worked in the dementia unit for six months. The activities coordinator has completed dementia training.  The service has exceeded the expected standard around evaluation of training to create improvements. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Low | Radius policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The clinical nurse manager works full time and another registered nurse works full time. Between the registered nurses seven days per week are covered. The facility manager and staff interviewed advised that extra staff can be called on for increased resident requirements and the roster. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.  A proposed roster has been developed to allow sufficient staffing including registered nurse cover when the service commences delivering hospital level care. The proposed roster includes an increased staff to resident ratio and a registered nurse on duty 24 hours per day in addition to the clinical nurse manager five days per week. Additionally the proposed roster includes an extra registered nurse on morning shift on Wednesdays and the weekends. Staff have not yet been employed to implement the new roster and this will require addressing prior to the admission of hospital level residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away in the nurses’ stations. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible and signed by the relevant healthcare assistant or registered nurse but do not consistently document the time of entry. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical nurse manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the clinical nurse manager. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are polices to describe guidelines for death, discharge, transfer, documentation and follow up. Records are kept with the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The service uses four weekly medico packs. Medication charts have photo identification. Blister pack medications are checked on arrival by the RN and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are kept in a locked medication room in both areas. Staff sign for the administration of medications on medication sheets held with the medicines. Nine out of fourteen medication files had occasions where not all regular non packaged medications were signed as administered. There were expired medications in the medication cupboard and in the fridge.  RN’s or senior caregivers administer the medication in both areas. Annual medication competencies are completed. Allergies are identified on the medication record. The registered nurse advised there were no residents self-medicating on the day of audit.  The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. The medication fridge is monitored daily (records sighted).  D16.5.e.i.2; Six out of fourteen medication charts reviewed, (one dementia, five rest home), did not identify that the GP had seen and reviewed the resident three monthly.  Three out of fourteen medication charts reviewed (one dementia and two rest home) did not have documented indications for use for all as required medications.  The medication system is able to provide an effective service for people receiving hospital level care. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | There is a large workable kitchen with two cooks. Both have completed food safety training. All residents have a nutritional and hydration care requirement developed on admission which is reviewed at the six monthly review. Copies were in a folder in the kitchen. Any special dietary requirements and food preferences are communicated to the kitchen and individual meals are supplied. The menu is designed and reviewed by a registered dietitian. Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented. Food temperature is checked and documented prior to serving.  There is evidence that there are additional nutritious snacks available over 24 hours.  The kitchen, kitchen equipment and kitchen staff are able to meet the needs of hospital level residents.  Equipment is available on an as needed requirement. Residents requiring extra assistance to eat and drink are assisted by healthcare assistants and were observed during lunch. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to residents should this occur and communicates this decision to residents/family/whanau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Comprehensive multidisciplinary assessments were completed in files sampled. All files reviewed had appropriate assessments on admission. Needs outcomes and goals of consumers were identified through the assessment process in files sampled. Residents and family are consulted and agree to intervention outcomes. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans sampled document interventions for all assessed needs and support. Files reviewed demonstrated that care plans were individualised. Care plans demonstrate service integration and demonstrate input from allied health.  Short term care plans are in use for changes in health status. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation reviewed and interviews with staff, residents and relatives identified that care is being provided is consistent with the needs of residents. Two hourly monitoring charts and behaviour monitoring charts were sighted in files sampled.  Residents' needs are assessed prior to admission. The service has a house GP that visits weekly or as required. During the tour of facility it was noted that all staff treated residents with respect and dignity.  Dressing supplies are available and a treatment room/cupboard 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.  Wound assessment and wound management plans are in place. The registered nurse interviewed described the referral process should they require assistance from a wound specialist. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There is a qualified diversional therapist that provides activities in the rest home and an activities coordinator that provides activities in the dementia unit across five days. The activity coordinator has completed the ACE dementia standards. The activities programme is able to cater for the needs of hospital level residents.  D16.5d  On the day of audit, residents were observed being actively involved with a variety of activities in the rest home and the dementia unit. The programme is developed weekly and displayed in large print. All residents are given a weekly plan. Residents have an activities/social profile assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, family etc.  The programme observed in the dementia unit was appropriate for older people with cognition and memory impairments. Activities are age appropriate and are planned. There are several programmes running that are meaningful and reflect ordinary patterns of life. There are also visits from community groups. Activities are provided by healthcare assistants outside the activity staff provided programme and at weekends.  Residents provide regular feedback around their likes and dislikes of the activity programme to the activity staff through monthly resident meetings or following activities. There are regular outings. Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.  A continued improvement rating has been awarded around providing an activities programme that caters to the specific needs of male residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | D16.4a Care plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Evaluations were documented and included progress to meeting goals. There was documented evidence of care plans being updated as required.  There is at least a three monthly review by the medical practitioner  There are short term care plans to focus on acute and short-term issues. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Discussions with the registered nurse (RN) identified that the service has access to external and specialist providers. Referral documentation was maintained on resident files sampled. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | The waste management policy & procedure outlines processes. Staff were observed wearing appropriate protective clothing. All chemicals sighted were appropriately stored in locked areas and fully labelled. There is an incident reporting system that is in use. A comprehensive emergency plan is available to staff in both nurses’ stations which includes hazardous substances.  Partial Provisional: An appropriate sluice room has been built in the wing where hospital level care is to be provided. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a current BWOF sighted dated expiry date 17/6/16. The facility is maintained in good order with regular maintenance. There is a comprehensive check system of the building and equipment to be carried out by the maintenance person. Electrical appliances that are not permanently wired are checked annually by a contracted service.  The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required.  The secure dementia has a separate lounge and dining area, they were both well supervised on the day of audit. There is a secure outside/garden area.  The external areas are well maintained and residents in both wings have access to gardens and indoor areas with ease.  The service exceeds the required standard around providing a safe environment and outdoor areas in the dementia unit  Two continued improvement ratings have been awarded around quality initiatives in the environment.  Partial Provisional:  The 20 rooms to be used for hospital level care are in one area of the facility. All rooms are large enough to cater for hospital level residents and their associated equipment and carers. There are wide corridors and a lounge and dining area that are able to cater for hospital level residents.  There is appropriate equipment available to meet resident’s needs. Suitable equipment to provide hospital level care has been ordered. Hoists have been purchased. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | PA Low | There are sufficient toilets and showers to cater for the existing rest home and dementia level residents. Many rooms have toilet ensuites.  Partial Provisional: There are two showers and one toilet in the wing to provide hospital level care that are suitable to provide care for hospital level residents. Prior to the admission of more than 10 hospital level residents the service will complete refurbishment of a second mobility toilet able to cater for hospital level residents is available. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids including those required by hospital level care residents. Residents are encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The communal areas include the main lounge and several smaller loungers and separate dining areas. The communal areas are easily and safely accessible for residents  Partial Provisional: The lounge and dining room in the hospital wing are large enough to cater for residents at hospital level care including fall out chairs and similar. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.  All laundry is done on site in the commercial laundry by dedicated laundry staff. Residents and relatives interviewed were satisfied with the laundry service. The laundry and cleaning services are able to cater to the needs of hospital level residents. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place.  A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.  There are call bells in the residents’ rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms and communal rooms including those to be used for hospital level care have an opening window to the outside. Heat pumps and under floor heating ensure warmth; all areas are warm and well ventilated. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Radius Windsor Court has an established infection control programme that is also able to cater to the needs of hospital level residents. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPI’s. The clinical nurse manager is the designated infection control nurse with support from the facility manager, the registered nurse and all staff (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Radius infection control programme was last reviewed in July 2014. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | CI | The clinical manager at Windsor Court is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff through the staff meeting) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.  The service has exceeded the standard around links with other providers. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are Radius infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the on-going education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | CI | Infection surveillance is an integral part of the infection control programme and is described in Radius’s infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Short term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Radius head office. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There have been no outbreaks since the previous audit.  The service has exceeded the required standard around the use of infection surveillance data to reduce infection rates. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimized. There were no residents with restraint or an enabler. All necessary documentation is available in relation to the restraints and enablers should these be required. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| **Citerion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 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. | PA Low | A proposed roster has been developed to provide satisfactory staffing to accommodate hospital level residents, based on 20 hospital level residents, 23 rest home level residents and 18 residents in the dementia unit. This has been developed using the Radius staffing rationale. The roster includes an average of 30.75 registered nursing hours and 123.5 health care assistant hours per 24 hours. Advertising for positions has begun with applications having been received. | Partial provisional audit: The service has not yet employed sufficient staff to implement the proposed roster to provide hospital level care. | Partial provisional audit: Ensure that sufficient staff with appropriate skills are employed (including sufficient registered nurses for 24 hour cover) to provide hospital level care.  Prior to occupancy days |
| Criterion 1.2.9.1  Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting. | PA Low | All progress notes are documented by a healthcare assistant at least every shift. Registered nurses document interventions in progress notes regularly. All progress notes in the seven files sampled (four rest home and three dementia) document the date. | Progress notes in seven of seven files sampled do not consistently document the time the entry was made. | Ensure all progress note entries document the time the entry was made.  90 days |
| Criterion 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. | PA Moderate | Medication policies align with accepted guidelines. Medications are stored in a locked trolley in a locked room in the dementia unit and rest home. The service uses four weekly blister packs. Medication charts have photo identification. There is a signed agreement with the pharmacy.  Staff sign for the administration of medications on the medication signing sheet. The medication folder includes a list of specimen signatures. | (i) Nine of fourteen medication administration signing sheets have occasions where ‘regular medications’ had not been signed as administered. (ii) Three of fourteen medication charts had ‘as required’ medications charted with no indication for use. (iii) There were expired medications in the medication cupboard and fridge. (iv) Six out of fourteen medication files did not have documented three monthly reviews, noting they have been completed in resident’s files. | i) Ensure all regular medications as signed as administered. (ii) Ensure all as required medications document indications for use. (iii) Ensure all expired medications are removed from medication cupboards and fridges and returned to pharmacy for disposal. (iv) Ensure GP documents medication reviews at least three monthly.  30 days |
| Criterion 1.4.3.1  There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use. | PA Low | There are sufficient toilets and showers to cater for residents in the dementia unit and rest home. Rooms have either shared ensuites or share communal ablution areas. The wing to be used for hospital level care (up to 20 residents) has an ensuite in each room but these are not large enough to cater for shower chairs or two staff. There are two large wet rooms for showering and one large toilet in that wing. Work has commenced to refurbish a second toilet/shower area so it can cater for hospital level residents. | Partial provisional audit: The service currently only has one mobility toilet in the wing to be used for hospital level care that is capable of catering to hospital level residents and associated equipment and carers. | Complete the refurbishment that has commenced to have a second mobility bathroom in the wing to provide for hospital residents.  Prior to occupancy days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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| **Citerion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | CI | There is an organisational business plan and Windsor Court has a April 2015 to May 2016 business plan with a series of measurable goals for the service that flow from the goals in the organisational plan. | The facility manager provides a documented monthly report to the Radius regional manager. The regional manager visits regularly and completes a report to the general manager Care Homes. The managers in the region meet monthly and a forum is held annually with all the Radius managers. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Windsor Court and forwarded to the regional manager. Meeting minutes reviewed included discussing on going progress to meeting their goals. Windsor Court’s annual goals also link to the organisations goals and this is also reviewed in quality meetings. This provides evidence that the quality goals are a 'living document'. Goals from the 2014 and 2015 business plan have either been met or carried forward. Examples include the goal around surveillance audits being met with no partial achievements. There was a goal to achieve 95% or above for internal audits. Thirty four audits completed between April 2014 and March 2015 scored 95% or above. The review includes details of actions completed for the five audits that scored 95%. The goals for the new year were set in April 2015 and are grouped around clinical effectiveness, consumer participation, human resources, risk management, revenue, property and being respected ;leaders in the field. Achievement for the first quarter against the goals has been documented and include the manager, clinical nurse manager and administrator attending the first leg of customer service training, no staff accidents in the quarter, no serious complaints (the report details the complaints which have been received), no unintentional weight loss and no restraint use and the progress of the falls reduction project. |
| Criterion 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. | CI | The manager at Windsor Court has worked in aged care since 2001 and has been in the current role since 2010. She has completed diplomas in business, human resources and small business management. | In 2014 the Radius business plan included a goal around the development of facility managers as leaders – for leaders to find the best in themselves. To innovate, develop their site and focus on their team to inspire positive behaviours that filter through the organisation. As a result of this the managers’ conference included leadership development around emotional intelligence, self-awareness, empathy, competence, personal influence and reflective practice, personality preferences and resonant and dissonant styles of leadership. Following this the Windsor Court manager completed self-directed learning using Boyatzis’ approach to self-directed learning during which she identified her strengths and weaknesses and through support and encouragement and mentoring from the regional manager gained confidence in having crucial conversations. She developed an understanding that leadership is about relationships, is everyone’s business and is self-development. She then identifies the management relationships of her senior team. Throughout 2014 and 2015 the Radius Waikato/Bay of Plenty regional managers have continued leadership training and this has resulted in further development for the Windsor Court manager. This has included training around skills of communication in interpersonal styles, skills of dynamic leadership, the five dysfunctions of a team, understanding cultures in the work place the Windsor Court likens her team to a bus journey now), and skills through the eight steps of successful change. As a result of this, a sense of urgency has been created at Windsor Court to achieve goals in the business plan (including the opening of hospital beds), there has been a pull together of the guiding team, a change vision and strategy for the site has been developed, there is better communication to all and understanding and buy-in (confirmed by staff interviewed), others in the team are empowered to act (noting staff innovations with scanners and white noise in the dementia unit – link 1.4.2.4), the development of triangle meetings weekly for the leadership team and daily reviews to the clinical team and communication to progress to the team with feedback of ideas. HCA’s interviewed reported positively around the improvements in focus and culture at Windsor Park and families interviewed reported that staff have a buoyant culture. |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | The service actively analyses data including benchmarking data against other Radius facilities and develops quality improvement plans in response to this data. | In November 2014 falls data was analysed and staff and management wished to address this. A quality improvement plan was developed with the proposed outcome to develop ‘a comprehensive programme that reduces harm from falls that responds to the personal, physical, logistical and environmental needs of individual residents allowing for independence and mobility while addressing privacy and dignity’. As a result of this programme all residents are now considered and treated as high falls risk on admission and a short term care plan identifying and addressing risks is developed at admission. A comprehensive review of all residents is undertaken by a multidisciplinary team with an emphasis that residents are partners in their care and have a responsibility to follow recommendations for falls reduction (e.g. use of call bells and hip protectors), where they are able. The environment and footwear are evaluated and useful aids identified. Each resident who is assessed to have on-going high risk has a documented monthly review by a multi-disciplinary team including overall health status, cognitive function, weight, number of falls, infections, GP consultations, activities participation and a comments from the physiotherapist. Residents are clinically reviewed when there is an acute or long term change in health status and short term care plans developed or long term care plans updated. As a result of these assessments the serviced has identified that the roller doors on studio units are hard to open and increase the risk of falls and this has been addressed and two residents now have raised toilet seats to reduce falls risk. The lighting in one corridor has been replaced with LED lights. Intentional rounding (documented sighting of residents within specified timeframes, usually half hourly or hourly) has been introduced for three residents and motion sensors have been installed in the dementia unit (link 1.4.2.4). One resident now has a higher walking frame. As a result of these interventions falls reduced in January, February and March 2015 and each of the 16 falls in May 2015 resulted in no injury. |
| Criterion 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. | CI | Windsor Court provides a wide variety of training that covers all required areas. Staff who do not attend compulsory trainings complete a competency questionnaire to ensure they are familiar with the contents of the training. | In late 2014 when reviewing staff attendance at trainings the facility manager identified that staff attendance was below the required standard. As a result she talked with staff in staff meetings and in one to one and group settings about what staff wanted to gain from training to attempt to improve staff perceptions of training. Staff reported their desired goals from training were personal growth, gaining new skills and self-fulfilment. Following this the facility manager began talking to all staff at the completion of each training about what could have been done better to meet staff needs in the training just completed. This was in addition to staff surveys completed about each training. This resulted in a training report sheet being developed to evaluate every training which includes a summary of training contents, the number of staff that attended and staff perspectives of the training. Importantly this provided feedback at a glance about whether sufficient staff had attended the training and gained the required skills. This form has been used to evaluate every training session provided in 2015. As a result of staff feedback and the evaluation forms, more external trainers from different agencies have been used as staff reported regularly repeated trainings could be boring. Some training sessions have had a variation repeated to capture more staff. As a result of this initiative staff training attendance has increased and staff feedback about training provided has improved. The registered nurse and health care assistants (HCA’s) interviewed reported that staff training has improved in 2015. |
| Criterion 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. | CI | The service provides an activities programme in both the rest home and the dementia unit that is designed to meet the needs of specific consumers and groups of consumers. Resident and family feedback is used to improve the programme. | The service has exceeded the standard around providing an activities programme that caters to the specific needs of male residents. In late 2013, the diversional therapist and activities coordinator identified that the number of men in the facility had increased and that attendance records and anecdotal evidence indicated that the programme was not well catering to the specific needs of some male residents. The service consulted with male residents about the kind of activities they would enjoy and also with their families. Additionally they consulted the male staff to provide topics or themes that would make interesting activities for male clients. In 2014, there have been the following activities, all attended by between seven and thirteen male residents: trip to the Avanti bike velodrome, male themed mosaics and tile cutting for shed mosaics, a trip to a car museum, a gazebo chit chat group and picnic, a picnic and beer by the lake, a Lake Ngaroto fishing trip, making bird houses attending Anzac celebrations with a nearby community and a BBQ and country and western singing group. Community male volunteers regularly attend events and three male residents and the families of two male residents interviewed reported great enthusiasm about the activities provided. Attendance records show that this initiative has increased the attendance and enjoyment of men in the activities programme and survey results indicate increased satisfaction from male residents. |
| Criterion 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. | CI | The service is active in improving the environment and identifying areas that can be adjusted to improve safety. An example includes increasing the lighting in one corridor as part of the falls project. All corridors are wide enough for residents to safely mobilise and to cater for residents with mobility equipment including hospital chairs for hospital level residents. | Staff in the dementia unit identified that a high number of residents were waking at night, in part due to being disturbed by minimal carer noise and in part by other residents who were awake. They also identified that sensor mats were not significantly reducing falls overnight as by the time the sensor mat was triggered the resident was already out of bed. This was resulting in falls at night in the dementia unit. Staff brainstormed and when traditional solutions appeared not to be working they became creative. One staff member knew from experience in another environment that background ‘white noise’ reduces the impact of other noises in the environment. The service then purchased a stereo and home theatre system and ‘white noise’ is played in the hallways from the time residents settle until the morning staff come on duty. This has resulted in less residents waking and the number of falls in the dementia unit at night has significantly decreased. Further to this staff brainstormed about how they could have an earlier indication that a resident was awake before they got out of bed and triggered the sensor mat to allow them to resettle a resident while still in bed if possible and to be with the resident if they were a high falls risk, prior to them getting out of bed. A series of ‘driveway scanner’ motion sensors were purchased and set up to detect motion just above the resident when they are sleeping so staff can be alerted if a resident starts significantly moving in bed, indicating they are awake. The staff carry the monitor which indicates which sensor has been triggered so they can respond quickly when a resident wakes. This has decreased the amount of noise made by residents who are awake, allowed residents to settle more quickly when awake and significantly reduced the number of falls overnight in the dementia unit. |
| Criterion 1.4.2.6  Consumers are provided with safe and accessible external areas that meet their needs. | CI | The service has a variety of courtyards and outdoor areas where residents can sit. Some residents enjoy gardening alongside the gardener. The dementia unit garden area is safe and secure. | In 2013, the dementia unit staff and management identified that the outdoor area at the dementia unit, while meeting requirements and being secure was not as safe as it could be and was not an especially inviting area for residents. There were a number of large mounds of earth with trees and shrubs on them. A plan to improve the area was developed and all trees and shrubs and getting a digger in to level the ground. The healthcare assistants determined that residents looked unsteady on the paving stones that provided a working path. Extra drainage was provided in the ground so it was not wet and the gardens designed so that the entire garden could be walked through, removing the need for a paved path. Planter boxes at waist height were installed and seta for residents to use provided around the area. Residents have been involved in planting and gardening and planter boxes contain herbs and vegetables that are used in salads in the dementia unit in summer. During the summer month’s residents regular enjoyed lunches in the garden as reported by HCA’s, activities staff and families interviewed. Families report that the residents make good use of the improved garden area and there have been no falls in the dementia unit garden since the upgrades were made. The satisfaction survey documents increased satisfaction with outdoor areas. |
| Criterion 3.2.1  The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard. | CI | The IC Coordinator receives on-going education and attended a DHB training day in May 2015. In the event of the IC coordinator requiring advice this is available through the GP, Pathlab or Bug Control. | Windsor Court has been strongly involved in the running of the WISS group – the Waikato infection control group for all aged care facilities in the region. The group meets bi monthly to provide mutual support around surveillance, outbreaks, meeting the health and disability service standards and education. The Windsor Court infection control coordinator is the treasurer for the group. The Windsor Court infection control coordinator identified that while it was not feasible for the group to meet more regularly there was a need for more support among members and that often issues could not wait two months. To address this he created a yahoo group which is an interactive group where conversations can be created by any member and any post or question asked by a member and any replies can be seen by all members. The site also includes links to other infection control topics and is a place where education resources can be shared. Topics covered have included Pathlab, Public Health, information provided by Smith and Nephew around wounds and outbreak management. The infection control coordinator reports this group is beneficial to all members and that he can gain advice quickly from other members if he requires this. |
| Criterion 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. | CI | All infections are logged, investigated and analysed each month and reported to monthly staff meetings. Information from trend analysis is used to develop quality improvement plans to improve the performance of the service around infection rates. | In 2015, Windsor Court has developed a goal to reduce their rate of infections to meet the KPI infection rates across Radius Care national rates within six months. This has involved monitoring infection rates and developing a plan each month with strategies to reduce the risk of recurrence of infections that have occurred. In May 2015 the infection control coordinator noted an overall drop in infection rates from the previous month with the number of UTI’s remaining static from the previous month. The analysis noted that the time of year meant residents are susceptible to respiratory illness so all staff were advised at the staff meeting to practice good respiratory hygiene and coughing etiquette al\t all times. Residents and families were also reminded of this through visual prompts placed at the entrance and throughout the facility. The education to staff included detailed information around measures to contain respiratory secretions and the use of droplet precautions. Additionally staff were reminded of the importance of mobility in reducing chest infections. Further to this additional measures were introduced to further reduce the rate of UTI’s including offering drinks when passing rooms and encouraging drinks at meal times as residents seem less keen to drink in colder months and the use of heating can be dehydrating. The infection rate has been measured monthly again the KPI’s for all categories and Windsor Court has been below the KPI or has met it (for KPI’s were no infections is the KPI) except in April 2015, following which additional education and interventions were introduced, resulting in the improvements again in May 2015 as noted above. |

End of the report.