

Radius Residential Care Limited - Radius Fulton Care Centre

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Radius Residential Care Limited
Premises audited:	Radius Fulton Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 30 September 2015 End date: 1 October 2015
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	77

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

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

General overview of the audit

Radius Fulton Care is owned and operated by Radius Residential Care Limited and cares for up to 93 residents requiring rest home, secure dementia or hospital level care. On the day of the audit, there were 77 residents. The service is managed by a facility manager who is well qualified and experienced for the role. The facility manager is supported by a clinical nurse manager and the Radius regional manager. The service has recently recovered from a significant flood resulting in the evacuation of many residents. The affected parts of the building reopened three weeks prior to the audit, with residents returning since this time. Residents, relatives and the GP interviewed spoke positively about the service provided.

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.

This audit has identified no areas for improvement. The service has exceeded the required standard around good practice, use of quality data, business goal planning and review, registered nurse (RN) education, use of infection control surveillance data, restraint minimisation, the activities programme, entry to the service and emergency management.

Consumer rights

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
---	--	--

Staff at Radius Fulton Care strives 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

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
--	--	--

The facility manager has been in the role for 13 years and an organisational team, a clinical nurse manager, registered nurses and care staff support her. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities, including Radius key performance indicators (KPIs), 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. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
---	--	--

The service has a well-developed assessment process and resident's needs are assessed prior to entry. The registered nurses complete assessments, care plans and evaluations. Residents/relatives are involved in planning and evaluating care. Risk assessment tools including the InterRAI assessment tool 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 medication management system follows recognised standards and guidelines for safe medicine management practice. Staff complete competency assessments.

Meals are prepared on site by a contracted company. Individual and special dietary needs are catered for. Residents interviewed responded favourably regarding 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.



Standards applicable to this service fully attained.

Radius Fulton Care has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. An authorised technician has calibrated medical equipment and electrical appliances. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. There is a designated laundry and cleaner's room. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. A recent weather generated emergency was managed in an exemplary way. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



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

Radius Fulton Care 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 two hospital residents with restraint and eight residents with an enabler. Restraint management processes are adhered to.

Infection prevention and control

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

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 as part of the ongoing 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.

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	7	43	0	0	0	0	0
Criteria	9	92	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (six healthcare assistants (three from the hospital, two from the rest home and one from the dementia unit), five registered nurses, one diversional therapist, two activities coordinators, the facility manager and the clinical nurse manager) confirm their familiarity with the Code. Interviews with 12 residents (eight rest home and four hospital) and four relatives (one rest home, one dementia and two hospital) confirm the services being provided are in line with the Code. Code of rights and advocacy training has been provided.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Resident admission agreements were signed in relation to the files sampled. Informed consent processes are discussed with residents and families on admission. Written consents were signed by the resident or their EPOA, in files sampled. Advanced directives are signed-for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Healthcare 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.</p> <p>Resident files sampled (four from the hospital, three from the rest home and two from the dementia unit)</p>

		have a signed admission agreements and consents.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>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.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>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 Fulton Care support ongoing access to community. Entertainers are invited to perform at the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints policy and procedures 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.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information is provided to residents and family members of Radius Fulton Care that includes the Code, complaints and advocacy information. Residents and relatives confirmed this on interview. The facility manager, clinical manager and registered nurses 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.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	<p>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</p>

<p>Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>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 regularly. 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 identify specific individual likes and dislikes. Staff education and training on abuse and neglect has been provided.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>There is a Radius Māori health plan and an individual's values and beliefs policy, which includes cultural safety and awareness. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau. Residents who identify as Māori have this included in their care plan. There is information and websites provided within the Māori health plan to provide quick reference and links with local Māori. Interviews with staff confirm they are aware of the need to respond appropriately to maintain cultural safety. Cultural safety training has been provided.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents interviewed indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives report that they feel they are consulted and kept informed. Family involvement is encouraged, for example, invitations to residents meetings and facility functions. Care plans reviewed include the residents' social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of</p>	CI	<p>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</p>

<p>an appropriate standard.</p>		<p>attend orientation and ongoing 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 acting facility manager and nursing staff. There are implemented competencies for health care assistants and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions. The service has exceeded the standard around good practice.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>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 confirmed they are notified of any changes in their family member's health status. The 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.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>CI</p>	<p>Fulton Care is part of the Radius Residential Care group. The service provides rest home, dementia and hospital level care. On the day of the audit, there were 22 rest home, 13 residents in the dementia unit and 42 hospital level residents. This included one resident on a younger persons with disability contract, one resident funded by ACC and one resident on a long term chronic conditions contract. There are 18 dual-purpose beds. The facility manager has been in the role for the past 13 years. The clinical manager (RN) has been in the role for one year, having previously been a clinical manager at another Radius facility. The facility manager reports to an operations manager and a weekly report has been provided. Radius has an overall business/strategic plan and Fulton Care has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement. The service has exceeded the standard around business goals and review of these. The facility manager has completed in excess of eight hours of professional development in the past 12 months.</p>

<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>In the absence of the facility manager, the regional manager is in charge with support from senior management team, the clinical nurse manager and care staff.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	CI	<p>There is an organisational business/strategic plan that includes quality goals and risk management plans for Fulton Care. There is evidence that the quality system continues to be implemented at Fulton Care. 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 also a monthly quality meeting where all quality data and indicators are discussed. Minutes of these meetings are 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 operations management team, 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 operations 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.</p> <p>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. Fulton Care has exceeded the required standard around the analysis and use of quality data to improve service delivery. 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 receives 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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	FA	<p>There is an accidents and incidents reporting policy. The clinical nurse manager investigates accidents and near misses and analysis of incident trends occurs. Incidents are included in the Radius KPIs (link</p>

<p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>1.2.3.6). Ten incident forms sampled demonstrated appropriate clinical follow up of incidents. There is a discussion of incidents/accidents at monthly staff meetings including actions to minimise recurrence. A registered nurse conducts clinical follow-up of residents. Discussions with the facility manager and regional management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. HealthCERT and the DHB were well informed around the recent evacuation. Public Health were notified of outbreaks in November and December 2014.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resource management policies in place, where 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. Nine staff files were reviewed and there was 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 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. The registered nurses are able to attend external training including sessions provided by the local DHB. The service exceeds the standard around training for registered nurses. Annual staff appraisals were evident in all staff files reviewed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Radius policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. At least one registered nurse and two healthcare assistants are rostered on at any one time. 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.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>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/whānau on admission. Information containing sensitive resident information is not displayed where other residents or members of the public can view it. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	CI	<p>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 facility manager and clinical nurse manager screen 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 information provided at entry includes examples of how services can be accessed that are not included in the agreement. Due to the recent flooding of the home in June 2015 and subsequent evacuation, a number of residents were transferred to other facilities and then readmitted in late August and early September. The service has coordinated the smooth transition of residents back in to the home following flooding, evacuation, transfer and readmission in a manner that exceeds the required standard.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies 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. During the recent flood and subsequent evacuation of residents, each resident had a bag of clothes, their files, care plans, medications and medication chart accompany them. There were staff available to go with the residents to the facilities and wards that they were transferred to. Some staff worked a shift at the accepting facilities to ensure that all residents were settled into their new environment (link CI #1.4.7.1).</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The service uses individualised robotic packs. Medication charts have photo identification. The RN checks robotic pack medications on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are kept in locked medication rooms. Staff sign for the administration of medications on medication sheets held with the medicines. Medication files reviewed evidenced that all regular non-packaged medications were signed as administered. There were no expired medications in the medication storage areas.</p> <p>RNs or senior healthcare assistants administer the medication. Annual medication competencies are completed. Two residents self-administer inhalers (one rest home and one hospital). Assessments, competency and reviews have been conducted.</p> <p>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</p>

		<p>(records sighted). Medications are reviewed at least three monthly by the attending GP.</p> <p>Three registered nurses and one health care assistant were observed administering medications correctly. Resident photos and documented allergies, or nil known, were noted on the sample of medication charts reviewed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals at Radius Fulton are prepared and cooked on site by a contracted food service company. The food service company operates the business from the commercial kitchen and provides meal service to a number of other aged care services and community colleges. The local council has certified the commercial kitchen. The food service company has a winter and summer menu, which had been reviewed by a dietitian in May 2015. Meals are served directly to rest home, hospital and dementia residents via bain-maries and tray service. The food service company are responsible for ensuring that all kitchen staff are trained in safe food handling and that food safety procedures were adhered to. Staff were observed assisting residents with their lunchtime meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the registered nurses or clinical nurse manager.</p> <p>Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	<p>The reason for declining entry to the service would be recorded on the declined entry form, and when this has occurred, the service stated it had communicated to the resident/family and the appropriate referrer.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a</p>	FA	<p>All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission, which formed the basis of resident goals and objectives. The InterRAI assessment tool was evident in all files reviewed (link CI #1.3.1). Assessments are reviewed at least six monthly. Appropriate risk assessments had been completed for individual resident issues in all files sampled. Four registered</p>

timely manner.		nurses and the clinical nurse manager (RN) have completed InterRAI training.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident files sampled included all required documentation. The long-term care plan recorded the resident's problem/need, objectives, interventions and evaluation for identified issues in files sampled. The service has a specific acute health needs care plan that included short-term cares. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Care plans sampled were current and interventions reflect the assessments conducted and the identified requirements of the residents. Interviews with clinical staff and relatives confirmed involvement of families in the care planning process. Dressing supplies were available and a treatment room was stocked for use. Continence products were available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice was available as needed and this could be described. Wound assessment and wound management plans were in place for all types of wounds.
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.	CI	There are three members of the activities team including one diversional therapist and two activity coordinators. One activities coordinator provides activities in the rest home and hospital and one activities coordinator organises activities in the dementia unit. The diversional therapist works across both areas. There is a separate programme delivered for rest home/hospital and dementia residents. The dementia unit programme is run over seven days. All three activity coordinators have completed the ACE dementia standards. The activities programme is able to cater for the needs of all levels of care provided at Radius Fulton Care. On the day of audit, residents were observed being actively involved with a variety of activities in the hospital, 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, and family. The programme observed in the dementia unit was appropriate for people with cognition and memory impairments. Activities are age appropriate and are planned. There are several programmes running that

		<p>are meaningful and reflect ordinary patterns of life. There are also visits from community groups.</p> <p>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 the care plan is reviewed.</p> <p>The service has exceeded the required standard around providing activities to meet residents' needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed by the registered nurses, had been evaluated 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.</p> <p>There are short-term care plans to focus on acute and short-term issues as evidenced in the files reviewed.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Discussions with the clinical nurse manager and the registered nurses (RN) identified that the service has access to external and specialist providers. Referral documentation was maintained on resident files sampled.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service</p>	FA	<p>The waste management policy and 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 in use. A comprehensive emergency plan is available to staff in nurses' stations, which includes hazardous substances.</p>

delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The service displays a current building warrant of fitness, which expires on 3 March 2016. Hot water temperatures are checked weekly. Medical equipment and electrical appliances have been tested, tagged, and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior areas are well maintained with safe paving, outdoor shaded seating and gardens. Healthcare assistants interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</p> <p>The refurbishment project, which was necessitated from the June flooding, has been completed. A certificate of public use has been issued and the building compliance schedule has been updated. The dementia unit, reception area and parts of the McKenzie rest home wing have been completed.</p> <p>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.</p> <p>The secure dementia area has a separate lounge and dining area, were both were well supervised on the day of audit. There are two secure outside/courtyard areas.</p> <p>The external areas are well maintained and all residents' wings have access to courtyard gardens and indoor areas with ease.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>There are a number of hospital/rest home resident rooms, which have ensuites. The remainder of hospital, rest home and dementia residents' share communal bathrooms and toilets. There were sufficient numbers of resident communal bathrooms and toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed state their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets and showers were well signed and identifiable and include large vacant/in-use signs.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed</p>	FA	<p>The resident rooms are spacious enough to meet the assessed resident needs. Residents were able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Healthcare assistants interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms are personalised.</p>

areas appropriate to the consumer group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are lounge areas and a separate dining room, and small seating areas. The dementia care level unit has a lounge/dining area. The main dining room was spacious, and located directly off the kitchen/server area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the residents. Residents interviewed report they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Dedicated cleaning staff clean the facility. 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.</p> <p>All laundry is done on site in the commercial laundry by dedicated laundry staff. Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>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 the 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. The service has exceeded the standard in the implementation of their emergency plan during the flooding of the facility in June 2015.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is rostered on and available at all times.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All communal and resident bedrooms have external windows with plenty of natural light. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	<p>FA</p>	<p>Radius Fulton Care has an established infection control programme. 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 KPIs. A registered nurse is the designated infection control nurse with support from the clinical nurse manager and the quality management committee (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 2015.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>A registered nurse at Fulton Care 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 the quality management team and care staff) 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.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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</p>	<p>FA</p>	<p>There are Radius infection control policies and procedures appropriate 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.</p>

<p>in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing 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 are appropriate to their needs and this is documented in medical records.</p>
<p>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.</p>	CI	<p>Infection surveillance is an integral part of the infection control programme and is described in Radius' 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 onto a monthly infection summary. This data is monitored and evaluated monthly and annually, and is 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 acting facility manager. Two outbreaks since the previous audit have been appropriately managed. The service has exceeded the standard around use of infection control surveillance data.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were two hospital residents with restraint and eight residents with an enabler. All necessary documentation has been completed in relation to the restraints and enablers. 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. Enabler use is voluntary. Staff education on RMSP/enablers has been provided. A restraint use audit has been conducted and restraint has been discussed as part of quality management meetings. A registered nurse is the current designated restraint coordinator.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>A registered nurse is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service completes comprehensive assessments for residents who require restraint or enabler interventions. Suitably qualified and skilled staff in partnership with the family/whānau undertook these. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the two restraint and three enabler files reviewed, assessments and consents were fully completed. Consent for the use of restraint was completed with family/whānau involvement and a specific consent for enabler/restraint form was used to document approval.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation manual identifies that restraint is put in place only where it is clinically indicated and justified and approval processes. There is an assessment form/process, which is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the files reviewed, however, documentation gaps were noted. Files reviewed had a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. In resident files reviewed, appropriate documentation has been completed. The service had a restraint and enablers register, which was updated each month.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service has documented evaluation of restraint every three months. In the three restraint and one enabler files reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality and staff meetings. Evaluation timeframes are determined by policy and risk levels. The evaluations sighted had been completed with the resident, family/whānau,</p>

		restraint coordinator and medical practitioner.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	CI	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. The restraint coordinator completes reviews. Any adverse outcomes are included in the restraint coordinators monthly reports and are reported at the monthly meetings. Six monthly restraint meetings have been held. The service has exceeded the standard around restraint minimisation.

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.

No data to display

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has a variety of mechanisms that are used to provide a good practice environment. The regional manager reported that learnings are shared across the Radius organisation. When interviewed the unit manager reported using these learnings and being aware that Fulton Care is geographically isolated from other Radius facilities, which provides different challenges than those of the other services in the organisation.</p>	<p>The service has exceeded the standard by providing an environment and service that has best practice initiatives. Examples of this include the quality improvement plans, which have resulted in a significant reduction in the number of falls at the facility (link 1.2.3.7), response to quality data analysis (link 1.2.3.6) and training initiatives for registered nurses. Further evidence is continuing improvement in resident surveys over the past four years with the rating for ‘the organisation exceeds, satisfies or not lives up to expectations’ improving, with no residents in the 2015 survey stating their expectations were not lived up to. In the 2015 survey, 90% of respondents would recommend a Radius facility to others.</p> <p>The intentional rounding concept was introduced at Radius Fulton in February 2014. It was originally documented as a system to do regular rounds and checking residents for a general review, for example, to ask for pain, toileting, drinks, repositioning or anything they may like (RN meeting minutes, February 2014). This was formally introduced following the Radius implementation of an intentional rounding policy in July 2014. Toolbox talks were provided for staff in March 2014, quality meeting minutes for July 2014 and RN minutes for August</p>

			<p>2014 show discussion and education around intentional rounding.</p> <p>The process was an integral factor in Fulton Care's ability to reach the set KPI of 26 falls/month by October 2014. The falls KPI continued to be met between October 2014 and January 2015.</p> <p>The system of implementing intentional rounding for residents' at high risk for falls continues, and is now part of standard care at the facility in falls prevention. In response to the reduced falls, the falls KPI set as part of the business plan review in April 2015, was reduced to a target of 18 falls/month (link 1.2.1.1).</p> <p>In September 2015 there was a total of 51 of 77 residents on intentional rounding. The frequency of the rounding is reviewed regularly. At the time of the audit, there were two residents where the intentional rounding is Q15mins and 12 further residents having the rounding completed every 30 minutes.</p> <p>The success of intentional rounding can be demonstrated by the following case study:</p> <p>Another resident was found on the floor and hourly intentional rounding was implemented. After sustaining two further falls the falls screening, risk assessments, individualised care plan, and post falls assessment and action plan were completed with frequency of intentional rounding increased to Q30 minutes. After further falls on the intentional rounding, frequency was increased to 15 minutes. Since then the resident has had no further falls and rounds were reverted to Q30 minutes. The resident has had no further falls and 30 minute rounding continues</p> <p>In July 2014 a quality improvement initiative (link 1.2.3.6) was created to improve the quality of skin care provided, to reduce the risk of skin related incidents (ie, pressure areas and skin tears), promotion of physical therapy, mobility, and re-positioning is a key component of this.</p> <p>The service identified in March 2015 that while they were good at implementing turns for residents who were immobile or for those who had a current pressure area, the frequency of the walking and repositioning of residents who sit for long periods was sporadic and not monitored on turning charts.</p> <p>To manage this Fulton Care has implemented the monitoring of two hourly repositioning where there is an identified clinical need and set 'walks' to ensure mobility is maintained in ambulatory residents, with a resulting reduction in pressure areas.</p>
--	--	--	--

<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	<p>CI</p>	<p>There is an organisational business plan and Fulton Care has an 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.</p>	<p>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 Fulton Care and forwarded to the regional manager. Meeting minutes reviewed included discussing ongoing progress to meeting their goals. Fulton Care'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, which was not achieved as there was one partial attainment. There was a goal to achieve 95% or above for internal audits which has carried over to 2015. The goal around employee resignations being below 5% was met. 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 included all internal audits to date achieving higher than 95% compliance, no serious complaints (the report details the complaints that have been received), no unintentional weight loss, good attendance at staff training and the progress of the falls reduction quality initiative.</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>CI</p>	<p>Radius Fulton Care collects and analyses quality data including complaints, accidents and incidents and infections. Data is benchmarked against set KPIs and corrective action plans are developed when targets are not met. Additionally, quality improvement initiatives are implemented when</p>	<p>Fulton Care exceeds the standard around the collection, analysis and evaluation of quality data and the actions and improvements that result from this analysis (link 3.5.7).</p> <p>Examples include (but are not limited to); In May 2015, the service identified that the incidence of falls was above the KPI target of 18. As a result, a corrective action plan was developed. This included expansion of falls prevention planning/input and a decision to discuss specific strategies at restraint meetings. In addition, the appointment of a falls prevention champion, mapping of resident falls, inclusion of residents in falls prevention plans by discussing progress at resident monthly meetings and purchase of additional falls prevention equipment, including two perimeter guards, two landing mats and two alarm</p>

		<p>opportunities for improvement are identified.</p>	<p>motion sensors. The plan was evaluated at least monthly and by August, falls had consistently remained below the KPI. At this time, the service decided to continue the focus on falls prevention and a quality improvement initiative plan was introduced. The actions implemented from this plan included continuation of education, including the 10 topics in falls prevention (reference: Health quality and safety commission New Zealand), the purchase of active hip protectors, where the goal is to reduce the likelihood of harm from fall. The promotion of physical activity, exercise/strength and balancing classes for residents, endorsement of charting of vitamin D for residents at high risk of falls and visual presentations of falls progress to communicate progress in a way all staff will be able to understand. Because of these actions (all of which have been implemented), the falls rate has reduced and there have been no falls resulting in serious injury.</p> <p>In July 2014, a quality improvement initiative was created to improve the quality of skin care provided to reduce the risk of skin related incidents, that is, pressure areas and skin tears, promotion of physical therapy, mobility, and re-positioning is a key component of this.</p> <p>The service identified in March 2015, that while they were good at implementing turns for residents who were immobile or for those who had a current pressure area, the frequency of the walking and repositioning of residents who sit for long periods was sporadic and not monitored on turning charts.</p> <p>To manage this the clinical nurse manager implemented the monitoring of two hourly repositioning where there is an identified clinical need and set 'walks' to ensure mobility is maintained in ambulatory residents.</p> <p>Hospital level care – Brookside wing:</p> <p>At the time of the audit there were 17 residents in Brookside wing; of these, six are independently mobile and walking is encouraged, and these residents had been reviewed systematically by the physiotherapist to ensure no functional decline, and were re-referred for any changes in mobility (evidenced in one file sampled).</p> <p>For another three of these residents they are assisted to walk at a length and level of assistance indicated by the physiotherapist. This was reflected in their care plan and documented on daily charts (sighted). The remaining eight residents are repositioned every two hours, stood up and have a change of position and or seat, and turned two hourly when in bed. Of these 17 residents</p>
--	--	--	---

			<p>there is only one hospital acquired pressure area.</p> <p>Hospital level care – Lisburn wing:</p> <p>Currently there are 20 residents in Lisburn wing; four of these residents mobilise independently, and they are encouraged to walk and are reviewed by the physiotherapist to ensure no functional decline, and are re-referred for any changes in mobility. Five residents are mobile with assistance and these residents are walked on each shift and are encouraged to change position (documented evidence sighted). The remaining six residents have a change of position every two hours; and this is documented on a turning chart. Of these residents, one resident has a stage two pressure area.</p> <p>Current skin care quality actions are around reviewing pressure-relieving equipment. This has been reviewed in conjunction with an external provider representative; all residents at risk of pressure areas are equipped with posture temp mattresses as a standard care intervention, and alternating air mattress supply increased accordingly.</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>The service provides a comprehensive in service education programme for all staff. Staff are encouraged to attend external training where this is available. Compulsory training sessions are often provided more than once to improve attendance and are followed up with a written competency assessment questionnaire.</p>	<p>In 2015, a quality improvement initiative was developed with a goal to continue to enhance the clinical knowledge of the RN team to ensure continuation of status as leaders in care. As a result of this a peer education; clinical lecture series consisting of head to toe systems review was commenced. To date this has included cardiovascular assessment (February 2015), neurovascular assessment (March 2015), gastrointestinal assessment (April 2015) and respiratory assessment (August 2015) (the service was affected by floods in June and July 2015). A further initiative was to optimise external training opportunities and to date in 2015, the following external training has been attended: March – APD dialysis training for RN team, one RN commencing InterRAI. April – Fundamentals of palliative care, resource meeting, APD training. May – broadening the concept of palliative care, mental health nursing forum, one RN commencing InterRAI. June – fundamentals of palliative care, syringe driver training. July – fundamentals of palliative care, mental health nursing forum, falls and fractures planning sessions, master classes in palliative care. August – syringe driver training, master classes in palliative care and September – Master classes in palliative care. In February 2015, a decision was made that external training knowledge would be filtered back through RN team. This has resulted in a presentation on death and dying in May 2015 and a</p>

			<p>toolbox chat on lessons learnt from palliative care master classes in September 2015. A further objective was around training in management of complex care and RN competence in management of peritoneal dialysis. This resulted in training around the management of CAPD peritoneal dialysis in March 2015 and the management of APD in June 2015. To further enhance organisational knowledge the CNM has prioritised attendance at clinical leadership forums including involvement/attendance at palliative care resource meetings, involvement in leadership forum for management of mental health care for the older person in residential care and an invitation to the Southern Alliance falls and fracture prevention steering group planning session in July 2015. The registered nurses interviewed report an increased knowledge and confidence because of the additional training and the healthcare assistants interviewed report that nurses are confident and knowledgeable.</p>
<p>Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	CI	<p>The Radius Fulton Care home was flooded in early June 2015 due to very heavy and sustained rain over a two-day period. The service was assisted by emergency services in the evacuation of 60 residents including all residents from the home's dementia unit. The service activated the emergency response plan and evidence was provided of the timeline of events (link CI # 1.4.7). The dementia unit required remodelling and repairs following the flooding. Starting on 26 August 2015, residents from the unit were transferred back to Fulton Care.</p>	<p>The service has coordinated the smooth transition of residents back in to the home following flooding, evacuation, transfer and readmission. The service evacuated 60 residents on the 3 June 2015 to either family or to other facilities including all of the dementia unit residents. Readmission of residents into the dementia unit began on the 26 August 2015 following refurbishment. The process of readmitting residents commenced with residents families being notified of the reopening of the unit, the receiving facilities were given three weeks' notice that residents could be readmitted to the dementia unit at Fulton Care and the needs assessment team were also informed. The end result of the readmission process was that 13 residents returned to the dementia unit. The service developed a staggered readmission process over one week to accommodate the cohort of these residents. Residents who were familiar and compatible with each other were admitted together to minimise the stress of transfer and readmission. As per the InterRAI assessment records for the facility, each readmitted resident was assessed with the InterRAI tool and a new care plan was developed within the required timeframes. On review of dementia resident files, the registered nurses had documented a short-term care plan around the admission process and transition back into Fulton Care home. The short-term care plan included behaviour triggers and de-escalation techniques, observation by staff for signs of stress and anxiety, and general re-orientation to the home. The service is to be commended on the timely and comprehensive way in which residents were readmitted, reassessed and care plans developed, making the transition back into the home as smooth and stress free for residents</p>

			as possible.
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service provides an activities programme in both the rest home/hospital and the dementia unit, which is designed to meet the needs of specific consumers and groups of consumers. Resident and family feedback is used to improve the programme. There is a strong focus on maintaining engagement with the local and international communities and encouraging residents to continue to contribute to others.</p>	<p>In April 2015, a combined ANZAC service was set up via Skype with an aged care facility in Australia. Both facilities contributed to the service, which was shown on a large screen television for all residents to view. Since April, there has been continued contact and involvement with the Australian facility with a plan of repeating the service on Armistice Day along with a link up with a facility in Hawaii. On the day of audit, the service linked via Skype with the Australian facility for a concert presented at Fulton Care. This has been happening on a monthly basis and serves as a rehearsal for the planned service in November. Residents interviewed advised that they enjoyed the Skype sessions and being able to make and foster contact with other residents in Australia.</p> <p>Operation Christmas Cheer is a six-week fundraising programme, which contributes to the Salvation Army food bank in preparation for Christmas. Residents, family, and staff contribute food items with a different theme each week. Advised by the activities coordinators that this programme is driven by the residents.</p> <p>Another fundraising project included a quiz with all funds raised donated to the Vanuatu relief fund. The residents and staff raised over \$1700 which was used to purchase specific items for children and families in Vanuatu including clothes, toiletries and seeds for vegetable growing. A local transport company provided free transport of the goods.</p> <p>For the past four years, the residents and staff have contributed to the breast cancer awareness fundraising project. A pink balloon day is held with proceeds donated to breast cancer research.</p> <p>International children's day is celebrated at Fulton Care with a tea party and a bouncy castle. Children and grandchildren of residents and staff are invited and an afternoon of fun and celebration.</p> <p>A group of residents visit a local school every fortnight for reading time with students. They take fruit platters for share with the children. Advised by residents and activities coordinators that this very much enjoyed by the residents and children.</p>

<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	<p>CI</p>	<p>Heavy rainfall over a short period of time, coupled with a high tide, resulted in extensive flooding in the south Dunedin area. The heavy and sustained rainfall over a 24-hour period caused flooding at Radius Fulton Care over the days and night of 3 and 4 June 2015. Initially flooding began in the laundry area, and then spread to the dementia unit and then two wings of the facility. The facility manager activated the Radius emergency response plan with assistance from staff, staff families, police, fire service, the local council, the needs assessment team, red cross, the local hospital, the DHB and civil defence. The facility manager documented the response of the service to the activation of the emergency management plan including a major incident log of the site flooding and evacuation, and then a recovery plan and time line including refurbishment work and readmission of residents.</p>	<p>The emergency plan was activated at approximately 11.00 am on 3 June 2015 until 3.00 pm hours on the 4 June 2015. The fire service and DHB were informed of the situation. The dementia unit residents were the first to be evacuated to the large hospital lounge area. As time progressed, it became evident that further evacuations were likely. Each resident had their belongings, medications, medication chart and file packed and labelled. Family members were contacted and those that could were able to take residents home. The evacuation process was well coordinated initially by the facility manager and then by the Southern DHB who took over the command of the evacuation of residents to other facilities and sites.</p> <p>The site flooding emergency response plan included an incident status report, a master transfer list and an incident log, which recorded the time line of events. By 9.00 pm on 3 June 2015, 60 residents had been evacuated. There were staff at Fulton Care who remained on duty for over 24 hours, caring for the remaining 33 hospital level residents.</p> <p>Recovery of the service following the emergency included regular resident meetings to keep them informed of the situation, staff visits to evacuated residents, continued input from the director of nursing for the Southern DHB, resident and family feedback, staff debriefing, staff communication, infection control implications and progress with the refurbishment project.</p> <p>The contracted firm for the refurbishment of the facility developed a site-safety management plan. This commenced on 9 June 2015 and completed on 25 August 2015. Residents were readmitted on the 26 August 2015.</p> <p>The response by the service, and in conjunction with the involvement of emergency services, resulted in well-orchestrated emergency response. Residents' needs were paramount and staff went over and above to provide continuity of care and to ensure that all residents were safe.</p> <p>The service has reviewed the emergency response plan and made updates in the form of an emergency response team list. No accidents or incidents were recorded in relation to the flood. A total of 17 compliments were received in relation to the emergency management, from families and residents and over 85% of residents who were evacuated have returned to Fulton Care.</p>
---	-----------	---	---

<p>Criterion 3.5.7</p> <p>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.</p>	<p>CI</p>	<p>The service collects infection control summary data for each unit, each month and this is analysed. The data is collated and sent to Radius Head Office where it is benchmarked against standardised data. The 2015 to 2016 business plan includes a goal around Fulton Care maintaining an infection rate below the KPI. Corrective action plans are developed and implemented if the service is above the KPI.</p>	<p>In July 2014 the service had more than 14 infections, which is above the KPI. A corrective action plan was developed. This includes ensuring detailed discussion of all infection trends at all meetings to ensure multidisciplinary input. This action has continued monthly and continues. The clinical nurse manager now updates the wound care register at least monthly to ensure appropriate wound care principles are maintained to reduce the risk of infection. This continues. Cleaning hours were reviewed and changed to improve the standard of hygiene. A separate corrective action plan was developed around this. The corrective action plan was amended in September 2014 to be more specific around reducing the prevalence of UTIs and conjunctivitis. Staff education was provided on 22 and 29 October 2014 and 26 February 2015 around hydration and its importance in UTI prevention. Following a norovirus outbreak in December 2014 the corrective action plan was again updated and red disposable linen bags were purchased for use for residents with infections. All staff were educated around the use of personal proactive equipment including the use of N95 masks and a staff debriefing was held to identify areas to improve performance in a future outbreak. Formal education was provided for all staff on lessons learned from the norovirus outbreak. In January 2015, the plan was further developed to implement a consistent monitoring protocol for residents with acute infections. These were developed with input from the RN team. As a part of this process individual infection monitoring forms were introduced to better monitor infections. In April 2015 education around the importance of the influenza vaccine was provided.</p>
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing</p>	<p>CI</p>	<p>The use of restraint is actively reviewed in facility meetings and by the restraint coordinator with a goal to minimise restraint use.</p>	<p>In August 2014, Radius Fulton Care identified that the number of restraints in use was above the Radius KPI for the service type. At this time, there were 13 restraints in use, all for hospital level residents. A corrective action plan was developed and a number of initiatives developed to minimise and reduce the restraint use at the facility. Staff training occurred over the last four months of 2014. The focus of the training (which included toolbox talks and formal training sessions), as evidence in interviews with healthcare assistant, the restraint coordinator and registered nurses and the clinical nurse manager, was to encourage staff to put themselves in the residents position and imagine what they may be needing that has made the resident restless and at risk of mobilising and then falling (which may previously have been managed with</p>

<p>restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education.</p>			<p>restraint use). Staff were encouraged to consider a number of needs were met if a resident presented as restless including providing fluids, food, repositioning or toileting if a resident appeared restless. The restraint coordinator and clinical nurse manager report working closely with families of residents using restraint to develop trust and educate the families around the risks of restraint use. These discussions are documented in the communication records of two resident files sampled where the resident had previously used bedrails as restraint. In addition, the service increased the use of intentional rounding (link 1.1.8.1) and purchased more perimeter guards, low beds and landing mats. The restraint coordinator, clinical nurse manager and healthcare assistants reported that the philosophy of restraint being a last resort became a living concept rather than a written philosophy. During the last four months of 2014, all residents using restraint had a comprehensive, multidisciplinary review of restraint use undertaken that included family input. One family interviewed confirmed this. In August 2015, following a new call bell system being installed, three residents who may otherwise have required restraint due to the risk of falling when mobilising had a dual alert system implemented where laser sensors alert staff via the call bell system if the resident is moving in their bed or chair. Additionally these residents have sensor mats in place. Following the implementation of these initiatives, the facility has reduced restraint use from 13 residents in August 2014 to two at the time of the audit.</p>
---	--	--	--

End of the report.