# Radius Residential Care Limited - Radius Thornleigh Park

## 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](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 Thornleigh Park

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 23 September 2015 End date: 24 September 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:** 56

# 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

Thornleigh Park is owned and operated by Radius Residential Care Limited and cares for up to 59 residents requiring rest home or hospital level care. On the day of the audit, there were 56 residents. The facility has a new manager that is well qualified and experienced for the role and is supported by a clinical nurse manager and the regional manager. 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 residents and staff files, observations and interviews with residents, relatives, staff and management.

This audit has identified areas for improvement around complaint documentation, family or resident involvement in care planning, InterRAI assessments and reviews, care planning, wound management, freezer temperatures, aspects of medication management and trial evacuations.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Staff at Radius Thornleigh Park 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 and communication. 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. A complaints register is maintained.

## Organisational management

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

The facility manager is a registered nurse 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, 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. 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

|  |  |  |
| --- | --- | --- |
| 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. |

Primarily the registered nurses or clinical nurse manager manages entry to the service. There is comprehensive service information available. A registered nurse completes initial assessments. Care plans and evaluations are completed within the required timeframe, by the registered nurses. Care plans are written in a way that enables all staff to clearly follow their instructions. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

## Safe and appropriate environment

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| --- | --- | --- |
| 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. |

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and several have their own toilet. There is sufficient space to allow the movement of residents around the facility using mobility aids including for residents at hospital level care in specific rooms. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management.

Emergency systems are in place in the event of a fire or external disaster.

## 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. |

Radius Thornleigh Park 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 no residents with restraint and there were two hospital residents with an enabler. Restraint management processes are adhered to.

## 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. |  | Standards applicable to this service fully attained. |

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. There have been no outbreaks since the last 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** | 0 | 37 | 0 | 5 | 3 | 0 | 0 |
| **Criteria** | 0 | 85 | 0 | 6 | 3 | 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 DeliveryConsumers 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 (eight healthcare assistants, one diversional therapist, one activities coordinator, two registered nurses, and three management personnel) confirm their familiarity with the code. Interviews with eight residents (five rest home and three hospital) and three relatives (three hospital) 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 ConsentConsumers 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. The resident or their EPOA signs written consents. 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. Eight of eight resident files sampled (five from the rest home and three from the hospital) have a signed admission agreement and consents.  |
| Standard 1.1.11: Advocacy And SupportService 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 identified 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 ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Interviews with residents and relatives confirmed 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 verified that they are supported and encouraged to remain involved in the community. Staff at Thornleigh Park support ongoing access to the 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.  | PA Low | A complaints policy and procedures are in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings and complaint forms. Information on the complaints 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 not all complaints and meetings held with the complainants are investigated. A complaints procedure is provided to residents within the information pack at entry. There was no documented evidence of all complaints being acknowledged or of outcome letters going to the complainant. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Information is provided to residents and family members of Radius Thornleigh Park that includes the Code, complaints and advocacy information. Residents and relatives confirmed this on interview. The facility manager, clinical nurse 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.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers 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 fortnightly. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirm the service is respectful and 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.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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 Māori heath 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.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | 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 (eg, invitations to family meetings and facility functions). Care plans reviewed include the residents’ social, spiritual, cultural and recreational needs. |
| Standard 1.1.7: DiscriminationConsumers 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 confirmed their understanding of professional boundaries.  |
| Standard 1.1.8: Good PracticeConsumers 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 ongoing in-service training. The resident satisfaction survey reflects reasonable levels of satisfaction with the services provided. Policies and procedures have been reviewed and updated at organisational level and they 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 stated that they feel supported by the facility manager and nursing staff. There are implemented competencies for healthcare assistants and registered nurse. There are clear ethical and professional standards and boundaries within job descriptions. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. A sample of incident reports and associated resident files reviewed, 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.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Thornleigh Park is part of the Radius Residential Care group. The service provides rest home and hospital level care. There are six dual-purpose beds. On the day of the audit, there were 16 hospital and 40 rest home level residents, this included two young persons with disability, one resident with a long term chronic health condition and one resident funded by Accident Compensation Corporation. The facility manager is a registered nurse and maintains an annual practicing certificate. She has been in this role for four months. A clinical nurse manager who has been in her role for two years supports the facility manager. The facility manager reports to a regional manager and a weekly report has been provided. Radius has an overall business/strategic plan and Thornleigh Park 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 facility manager has completed in excess of eight hours of professional development in the past 12 months.  |
| 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 regional manager is in charge with support from senior management team, the clinical nurse manager and care staff.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is an organisational business/strategic plan that includes quality goals and risk management plans for Thornleigh Park. There is evidence that the quality system continues to be implemented at Thornleigh Park. 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. The quality and risk management programme is designed to monitor contractual and standards compliance. The clinical managers group with input from facility staff reviews the service’s policies at national level, 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 bi-monthly. Restraint and enabler use is reported within the general staff 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.  |
| 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. The clinical nurse manager investigates accidents and near misses and analysis of incident trends occurs. Incidents are included in the Radius KPIs. 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 for each of the 10 incident forms sampled. Discussions with the facility manager and regional management team confirm 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 evidenced 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 facility manager and registered nurses are able to attend external training including sessions provided by the local DHB. Annual staff appraisals were evident in all staff files reviewed. Four of six registered nurses have completed InterRAI training. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | 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, especially registered nurses will be increased as the ratio of hospital residents increases. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | 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. Other residents or members of the public cannot view information containing sensitive resident information. 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. |
| 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 policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. |
| 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 medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy. Medication prescribed is not always signed as administered, on the pharmacy generated signing chart. CD checks were not all completed weekly.Registered nurses administer medicines. All staff that administer medication are competent, and have received medication management training. The facility uses a blister pack medication management system for the packaging of all tablets. The RN on duty reconciles documents the delivery. Medication charts for regular medications (not for all ‘as required’ medications), are written correctly by medical practitioners and there was evidence of three monthly reviews by the GP. No current residents self-administer medicines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | PA Low | There is a fully functional kitchen and all food is cooked on site. A food services manual is in place to guide staff. A resident nutritional profile developed for each resident on admission, is provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu, which has been reviewed by a dietitian. The temperature of cooked foods is monitored and recorded. There is special equipment available for residents if required. All food in the pantry is stored appropriately. Temperatures are not recorded for all fridges and freezers and one freezer was above the safe temperature range. Residents and the family members interviewed were very happy with the quality and variety of food served. |
| 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/whānau. 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. | PA Low | All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools are available and completed. Overall assessments were reviewed at least six monthly or when there was a change to a resident’s health condition (link 1.3.3.3). Care plans are developed on the basis of these assessments. The service has begun implementing the InterRAI assessment tool. No residents admitted since 1 July 2015 have had an InterRAI assessment completed.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | In four of eight resident files reviewed, the long-term care plans described the support required to meet the resident’s goals and needs, and identified allied health involvement. Residents and their family/whānau are not always involved in the care planning and review process (link 1.3.3.4). Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Registered nurses (RNs) (including the clinical nurse manager) and healthcare assistants follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the wound nurse specialist). If external medical advice is required this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Ten of 12 wound documentation reviewed, included wound assessments, monitoring and wound management plans. There were three residents with pressure areas (one grade one and two grade two). One resident was admitted with a pressure injury (link hospital tracer). Wound documentation did not reflect that all wounds had been reviewed in the timeframe stated. The RNs have access to specialist nursing wound care management advice through the DHB.Care plans reviewed included interventions to support monitoring of at risk residents including (but not limited to); intentional rounding, turning charts and food and fluid charts. Charts reviewed were up to date.  |
| Standard 1.3.7: Planned ActivitiesWhere 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 | An activities coordinator is employed full time to operate the activities programme for all residents and is supported by a part time activities assistant. Each resident has an individual activities assessment on admission and from this information an individual activities plan is developed as part of the care plan by the registered nurses, with input from the activities staff. Residents are free to choose whether to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. All resident files sampled have a recent activities plan within the care plan and this is evaluated at least six monthly when the care plan is evaluated. Residents and families interviewed commented positively on the activity programme. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In the files reviewed, the registered nurses (RN) evaluated all initial care plans within three weeks of admission. Overall, in the care plans reviewed, changes in health status were documented and followed-up (link 1.3.5.2). An RN has signed care plan evaluations. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| 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 | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident’s condition had changed and the resident was reassessed.  |
| 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 | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were stored safely throughout the facility. Safety data sheets are available.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness. The building has a number of alcoves and lounge areas. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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. | FA | There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Several bedrooms have their own toilets and one has a full ensuite. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.  |
| 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. Residents are encouraged to personalise their bedrooms.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers 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, several smaller lounges, and main and smaller dining areas. The communal areas are easily and safely accessible for residents. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | 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 of the facility.All laundry is done off-site except kitchen laundry and personal items, which are managed by dedicated laundry staff, in the on-site commercial laundry. Residents and relatives interviewed were satisfied with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | 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. There has not been a trial evacuation in the past six months. 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 | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.  |
| Standard 3.1: Infection control managementThere 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 Thornleigh Park 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. The clinical nurse manager is the designated infection control nurse with support from the facility manager, supporting regional clinical 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 has been reviewed annually. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The clinical nurse manager 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.  |
| Standard 3.3: Policies and proceduresDocumented 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 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 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 provided to residents and visitors is appropriate to their needs and this is documented in medical records.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | 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 and 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 acting facility manager. An outbreak in 2014 was appropriately managed and reported. |
| Standard 2.1.1: Restraint minimisationServices 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 minimised. There were no residents with restraint and two hospital residents with an enabler. All necessary documentation has been completed in relation to the 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.  |

# 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.3An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | A complaints register is maintained for all complaints received. Residents and relatives confirmed on interview that they knew how to make a complaint. Not all complainants are informed in writing of the outcomes of investigations. | In three of eight complaints reviewed the complaints register had no documented evidence of an acknowledgement letter or outcome letter being sent to the complainant.  | Ensure all complaints are acknowledged within five working days and the complainant receives a documented outcome of the complaint.90 days |
| Criterion 1.3.12.1A 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 | The service stores medication safely. The medication fridge temperature is recorded daily. A small stock of imprest medication is maintained. Weekly controlled drug stocktakes have not always occurred. All residents have a pharmacy generated medication chart signed and updated by the GP. Not all ‘as required’ medication documents an indication for use documented. Medication administration charts are generated by the pharmacy and are accurately singed for all blister packed medications on medication profiles sampled. Not all non-packaged, regular medications were signed as administered. | (i) controlled drug checks have not occurred weekly.(ii) Three of 16 medication charts sampled have as required medications prescribed (for midazolam and OxyContin) with no indication for use documented.(iii) Three of 16 medication administration records do not have all prescribed medications signed as administered.  | (i) Ensure controlled drug-checks occur weekly.(ii) Ensure ‘indication for use’ is documented for ‘as required’ medications.(iii) Ensure that medication is administered as prescribed.60 days |
| Criterion 1.3.13.5All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | The service has a main chiller, a fridge in the kitchen and a fridge in one kitchenette. There are three freezers in the kitchen. Temperatures are recorded daily for the chiller and the fridge in the kitchen (not the fridge in the kitchenette). One freezer temperature fridge is recorded daily. It is unclear which freezer the recorded temperature was for. One freezer was sighted to be above the safe temperature range, according to the thermostat display outside the freezer. | There are three freezers and only one temperature has been recorded. One freezer has an external thermostat, which was at -7 degrees Celsius during the audit and the kitchen manager was unaware that this was outside the safe range. Temperatures were not recorded for the fridge in the kitchenette.  | Ensure that individual temperatures are recorded for all fridges and freezers and that these are maintained in a safe temperature range.60 days |
| Criterion 1.3.3.3Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | All eight resident files sampled had an initial assessment and care plan completed on the day of admission and a long-term care plan completed within three weeks of admission. All care plans had been evaluated six monthly where the resident had been at the service longer than six months. All residents who were not admitted from hospital had been assessed by a GP within two working days of admission. GPs had documented that residents were stable for three monthly review. | The InterRAI ‘assessment due’ summary documented that nine InterRAI assessments were overdue for review. This included one of the eight files sampled (from the rest home). | Ensure all InterRAI assessments are reviewed at least six monthly or when needs change.90 days |
| Criterion 1.3.3.4The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | The clinical nurse manager reported that where she is able, she discusses care plans with the resident or their family and following this discussion has the resident sign the care plan. The eight residents interviewed reported they were aware of the cares being provided. The resident or their family had not signed all care plans sampled.  | Two of four residents care plans sampled (from the hospital) do not have documented evidence of resident or family input. | Ensure there is documented evidence for all care plans of resident and/or family input.90 days |
| Criterion 1.3.4.2The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | A comprehensive suite of paper-based assessment tools is available and had been repeated six monthly in files sampled. One resident file sampled had an InterRAI assessment completed in February 2015, which has not been reviewed (link 1.3.3.3). The InterRAI assessment due report, documents others that have not been reviewed. The InterRAI tool is not being used for new admissions. | None of the six residents admitted since 1 July 2015 (two to the hospital and four to the rest home), have had InterRAI assessments completed. | Ensure that an InterRAI assessment is completed for every new admission.90 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | All resident files had a care plan completed by a registered nurse within three weeks of admission. Care plans are developed using a comprehensive templated tool. Care plans include (but not limited to) pain management, activities of daily living, sleep and rest, and behaviour management. Not all care plans had all identified needs addressed. | Four of the eight care plans sampled (three from the hospital and one from the rest home) did not have interventions documented for all assessed needs. Examples included falls management, use of a sliding sheet, weight management, management of hypo and hyperglycaemia and regular turns. | Ensure that care plans document interventions for all identified areas of need.60 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Wound documentation available includes a wound assessment and management plan (which was completed for 10 of 12 current wounds) and a wound review chart, which documents the timeframe for the review of the wound and the current state of the wound. Not all wounds had been reviewed within the stated timeframe. | Two of the three pressure areas at the facility did not have a comprehensive assessment completed.Four of the 12 current wounds (including two of three pressure areas) have not been reviewed within the stated timeframe. | Ensure all wounds have a comprehensive assessment and are reviewed within the stated timeframe. 60 days |
| Criterion 1.4.7.1Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Low | Staff have had training around fire safety and the management of other emergencies. There was a fire drill in February 2015.  | There had been no fire drill in the past six months. The risk is low as a fire drill is booked with the New Zealand Fire Service for 9 October 2014 (email confirmation sighted). | Ensure fire drills are conducted at least six monthly.60 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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End of the report.