

# Radius Residential Care Limited - Radius Elloughton Gardens

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## Introduction

This report records the results of a Surveillance 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:

<b>Legal entity:</b>	Radius Residential Care Limited
<b>Premises audited:</b>	Radius Elloughton Gardens
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 13 March 2017 End date: 14 March 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	74

# Executive summary of the audit

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## 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 Elloughton Gardens is part of the Radius Residential Care Group. Since the previous partial provisional audit, the new wing has opened and Elloughton Gardens now cares for up to 86 residents requiring hospital and rest home level care. On the day of the audit, there were 74 residents.

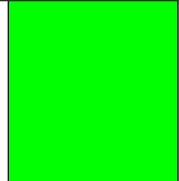
The facility manager has a social work background and has been in the role since June 2015. He is supported by a clinical manager who has been in the role for one year and the Radius regional manager.

Residents and family interviewed spoke positively about the service provided. The one outstanding shortfall identified at the previous certification audit has been addressed. This was around restraint monitoring.

Ten of the eleven shortfalls identified at their previous partial provisional audit have been addressed. These were around completion of the building including: the sluice rooms; the kitchen; the laundry; all painting and covering of walls and windows; the call bell system; landscaping of external areas; the turning on and monitoring of hot water; having the evacuation plan approved by the New Zealand Fire Service and obtaining a certificate for Public Use. Sufficient staff have been employed to ensure the roster is filled. Electronic resident monitoring records demonstrated that monitoring of residents is completed and reviewed by registered nurses in the new electronic database as required.

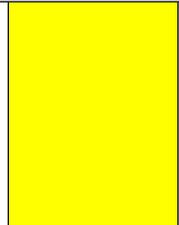
Improvement continues to be required around the orientation/training of new staff. This audit identified two further improvements required around monitoring of fridge temperatures in resident's areas where residents own food is kept and developing a corrective action plan to address survey results.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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There is evidence that residents and family are kept informed and open disclosure is practiced. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated and are appropriate to the needs of the residents. A facility manager is responsible for the day-to-day operations of the facility. Quality and risk management processes are documented. Strategic plans and quality goals are documented and regularly reviewed. A risk management programme is in place, which includes a risk management plan and health and safety processes. Human resources are documented and education is provided for staff. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

## 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 low risk.
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Initial assessments and risk assessment tools are completed by the registered nurses on admission. Registered nurses are responsible for care plan development with input from residents and family. Care plans document interventions to guide staff in ensuring residents needs are met. Activities are appropriate to the residents assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed in line with legislation and current regulations. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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.
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A current building warrant of fitness (for the original building) and certificate of public use (for the new area) are posted in a visible location. All areas of the building have been completed and areas that require secure access have been secured with keypad locks. There is appropriate equipment available and this has been serviced and/or calibrated. Outdoor areas have been landscaped. There is an approved evacuation scheme and operational call bells. The hot water has been turned on and is maintained at a safe temperature.

## 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.		Standards applicable to this service fully attained.
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The service has alternative systems available so that staff can use restraint as a last resort strategy. There was one resident voluntarily using bedrails as enablers on the day of the audit. Care plans include reference to the use of enablers. Two residents were using restraints. Restraint monitoring is documented in the electronic database.

## 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.		Standards applicable to this service fully attained.
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Elloughton Gardens has an infection control programme that complies with current best practice. Infection control surveillance is established and is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

## 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)
<b>Standards</b>	0	17	0	3	0	0	0
<b>Criteria</b>	0	43	0	3	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are accessible to residents and family. Information about complaints is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Care staff interviewed (six healthcare assistants, two registered nurses and one activities coordinator) described the process around reporting complaints.</p> <p>Verbal and written complaints received are recorded on a complaint register. There is evidence that these complaints have been managed in a timely manner including acknowledgement, investigation, meeting timelines, corrective actions when required and resolutions.</p> <p>All complaints were reviewed from 2016 (18 from 13 complainants) and 2017 year to date (eleven from seven complainants). All were managed within the required timeframes as determined by the Health and Disability Commissioner. One complaint regarding a resident who passed away after leaving the facility is the subject of a complaint to Radius from the family's lawyer, a copy of which was also given to the Health and Disability Commission and is the subject of a current coronial enquiry. A review of documentation around these complaints indicated that the Health and Disability Advocacy Service supported the family with the complaint</p>

		<p>and met with the family and management at Elloughton. In August 2016, the Health and Disability Advocacy Service wrote to Elloughton to say that the family were now satisfied and the file was closed. The Health and Disability Commission notification of the complaint was received during the audit. One resident has made three complaints which have been unable to be substantiated in 2017. Radius leadership did not make a section 31 notification regarding these complaints, despite the serious nature, due to the vague nature of the complaint. Another complaint related to an alleged assault in 2017. HealthCERT and the DHB have been involved with this complaint which has been appropriately investigated and managed by the service.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>An open disclosure policy describes ways that information is provided to residents and families. Residents interviewed (three rest home and two hospital) stated that communication is open. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay that is not covered by the agreement. Regular contact is maintained with family including if an incident or care/health issues arises. Four families (one from the rest home and three from the hospital) interviewed stated they were kept well informed. Thirteen incident/accident forms were reviewed and identified that the next of kin were contacted or if not, justification as to why. Residents' meetings are held two-monthly.</p> <p>The service can access interpreter services through the district health board. The information pack is available in large print and can be read to residents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Radius Elloughton Gardens is part of the Radius Residential Care Group. Elloughton cares for up to 86 residents requiring hospital and rest home level care. Sixty-six rooms can be used for either hospital or rest home level care. On the day of the audit, there were sixteen rest home level residents and fifty-six hospital residents including one funded by ACC and one on a short-term respite stay. All other residents were on the ARC contract. The new building opened in stages from mid-December 2016.</p> <p>The Radius Elloughton Gardens business plan April 2016 to April 2017 is linked to the Radius Care Group strategies and business plan targets. The mission statement is included in information given to new residents. An organisational chart</p>

		<p>is in place. Comprehensive quarterly reviews are undertaken to report on achievements towards meeting business goals.</p> <p>The facility manager has a social work background and began employment in the role in June 2015, having previously managed aged care services. He is supported by a clinical manager who has been with Radius since 2013 and in the current role for one year and the regional manager.</p> <p>The facility manager has maintained more than eight hours of professional development activities related to managing an aged care facility.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>A quality and risk management system is in place. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Policies and procedures have been updated to reflect the implemented interRAI procedures.</p> <p>The monthly collating of quality and risk data is completed by the clinical manager and is comprehensive, including monitoring clinical effectiveness, work effectiveness, risk management/falls and consumer participation. Data is collated and benchmarked against other Radius facilities. The clinical manager undertakes a comprehensive analysis of all incidents including time of day, place and staffing at the time of the incident. This analysis is also undertaken for pressure injuries, which are including in the benchmarking programme. A resident satisfaction survey is conducted each year. Results for 2016 reflected areas where satisfaction had declined and could be improved. However, no corrective action plan was developed around this. An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified within the internal auditing programme. There is evidence of these corrective actions being communicated to all staff and regularly evaluated. They are signed off by management when completed.</p> <p>Falls reduction strategies include: staff knowing the residents who are at risk; managing challenging behaviours effectively; adhering to residents' routines and anticipating their needs; and intentional rounding with frequencies determined by the resident's risks of falling. All healthcare assistants utilise transfer belts to minimise resident harm from falls.</p> <p>The maintenance person is the health and safety representative. Health and safety is discussed at weekly triangle of support (leadership) meetings and monthly staff meetings. The health and safety representative has completed training relevant to</p>

		the role and ensures hazards are promptly addressed. Staff interviewed were familiar with the process to eliminate, isolate or minimise the risk from hazards and concurred that hazards are promptly addressed. The hazard register includes site specific and current hazards.
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>	FA	<p>The service collects data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. Thirteen incident forms sampled demonstrated that the reporting system is integrated into the quality and risk management programme. Once incidents and accidents are reported, the immediate actions taken are documented on incident forms. The incident forms are then reviewed and investigated by the clinical manager who undertakes detailed trend analysis. If risks are identified, these are processed as hazards using a hazard identification form.</p> <p>A discussion with the facility manager has confirmed his awareness of statutory requirements in relation to essential notification. Appropriate notifications have been made around pressure injuries and a serious complaint.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Since 1 April 2016, there have been eight HCA resignations (22.8%), a total of thirteen new HCA's commence employment and four of the permanent RN's have resigned. In addition to the replacement of these four RNs, a further four have commenced. The service now has sufficient staff to cover the roster and this is an improvement since the previous audit.</p> <p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of health professionals are current. Five staff files were reviewed (two healthcare assistants, the clinical manager, one registered nurse and the activities coordinator). Evidence of signed employment contracts, job descriptions, orientation and training were available for sighting. Annual performance appraisals for staff were completed in files sampled. Newly appointed staff complete an orientation that is specific to their job duties. However, a comprehensive orientation covering all core aspects of rights and service delivery continues to be required to ensure sufficient skill base due to the high number of inexperienced staff. Interviews with care staff described the orientation programme that includes a period of supervision. They commented that staffing was an issue due to the number of inexperienced staff not having all the skills and knowledge required.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented and attendance is recorded. All staff complete a</p>

		range of competency assessments. Five of the eleven registered nurses have completed their interRAI training and a further two are in the process of completing. There is always a staff member on duty with a current first aid/CPR certificate.
<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>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The clinical manager is a registered nurse and works 40 hours per week as well as covering on-call duties.</p> <p>There are three registered nurses on morning shift, one registered nurse who works from 1 pm to 9.30 pm, three who work a full afternoon shift and one on night shift. They are supported by 12 healthcare assistants (HCA) who work an 8-hour morning shift (starting at either 6.30 am or 7 am), 8 who work an 8-hour afternoon shift (starting at either 2.30 pm or 3 pm). There is also a HCA who works 4.30 pm to 11 pm, a HCA who works 5 pm to 10 pm and 4 HCAs who work night shift.</p> <p>Staff reported that staffing levels and the skill mix are appropriate but that the lack of sufficient orientation for the high number of new staff meant that completing tasks to a high standard in appropriate timeframes was difficult (link 1.2.7.4). All families and residents interviewed advised that they felt there was sufficient staffing. The roster is able to be changed in response to resident acuity.</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>All medications are stored in the treatment room in the original building. The room that was planned to be a treatment room in the new building is not used as a treatment room and is no longer intended to be. This has addressed the previous partial provisional shortfall. Medications are checked against the doctor's medication profile on arrival from the pharmacy by a registered nurse. Any mistakes by the pharmacy are regarded as an incident.</p> <p>Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. A registered nurse was observed safely and correctly administering medications. All prescribed medications on charts reviewed had been signed as administered.</p> <p>Resident medication charts are identified with demographic details and photographs. The medications fridges are monitored daily. All 10 medication charts had allergies (or nil known) documented.</p> <p>There is one resident who self-administer medications. A completed competency assessment was sighted for this resident.</p> <p>Eight of ten (two residents had been at the service less than three months)</p>

		<p>medication charts reviewed identified that the GP had reviewed the resident three-monthly and the medication chart was signed. All medication charts document the indication for giving the PRN medication. All eye drops were dated on opening.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>The large commercial kitchen is new following the addition of the new wings and is fully fitted out and functional. This is an improvement since the previous partial provisional audit. At the time the new kitchen became operational, an external contractor with an existing relationship with Radius took over the operation and oversight of the kitchen. The contracted provider employs sufficient kitchen staff to provide meal services over seven days a week. There is a rotating four-weekly menu in place that is designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed.</p> <p>Food safety information and a kitchen manual are available in the kitchen. Food served on the day of audit was hot and well presented.</p> <p>The residents interviewed spoke positively about meals provided and they all stated that they are asked by staff about their food preferences.</p> <p>The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires. Temperatures are not recorded for the fridges in the dining areas. All food is stored and handled safely. Food temperatures are recorded. The kitchen is clean.</p> <p>Kitchen staff have been trained in safe food handling.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Wound care plans, infection control plans, fluid balance management plans and pain management plans were evident in the electronic database. Where a care plan identified a regular intervention being required such as turns, intentional rounding or pain monitoring, the database alerts staff at the time the intervention is due. All five files reviewed showed that monitoring and interventions are being completed as required. This is an improvement since the previous audit. Registered nurses check off all monitoring charts each day. This is also an improvement since the previous audit.</p> <p>The use of short-term care plans was evident. In all files sampled and following observation and interviews with staff and residents, the residents are receiving care that meets all their needs. The GP interviewed stated the facility applied changes of care advice immediately and was complimentary about the quality of service delivery provided. Resident's needs are assessed prior to admission and resident's primary care is provided by the facility GPs unless the resident chooses another</p>

		<p>GP.</p> <p>Dressing supplies are available and a treatment room is stocked for use.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use and other management.</p> <p>Specialist continence advice is available as needed.</p> <p>Wound assessment and wound management plans were in place for all residents with wound including skin cancers, skin tears and a surgical wound. The wound rate appears high as one resident with very fragile skin has 13 wounds. There was wound documentation for all wounds including two unstageable pressure injuries (one externally acquired and one facility acquired), two stage III (one externally acquired and one facility acquired), five stage II (all facility acquired) and four stage I (three facility acquired and one externally acquired). There is evidence in files of the wound specialist referrals. Wound care is completed within timeframes. All resident care plans were sampled for the ten residents with the thirteen pressure injuries. All had comprehensive interventions across a variety of domains and included appropriate equipment and monitoring. The clinical manager had identified the high number of pressure injuries and on 2 February 2017, developed and implemented a corrective action plan with a goal to prevent pressure injuries. Actions included a top-to-toe assessment of every resident, regular skin clinics with a doctor and clinical nurse specialist at Elloughton since 13 February 2017 and education for RN's on 9 February 2017. There has been close liaison with the charge nurse of the DHB AT&amp;R ward who has stated 'everything that can be done is being done'. On 22 February 2017, a staff workshop was held that covered that all pressure injuries are preventable, that every member of staff, regardless of their role, has responsibility in pressure injury prevention, that vigilance is needed by care staff and that prevention of pressure injuries is a priority for the Ministry of Health. On 3 February, the Director of Nursing for the DHB and the AT&amp;R charge nurse visited Elloughton and reviewed the electronic file for each resident with a pressure injury and inspected one resident's wounds. The manager and clinical manager report they were satisfied with the level of care being provided.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to</p>	<p>FA</p>	<p>Elloughton Gardens now has two full-time activity officers (this has increased with the resident numbers increasing) who work in the facility across both service levels. All recreation/activities assessments and reviews were up to date in the electronic database for the files sampled. On the day of audit, residents were observed being</p>

<p>their needs, age, culture, and the setting of the service.</p>		<p>actively involved with a variety of activities in the main lounge and throughout the facility. Residents have a comprehensive assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career and family.</p> <p>Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life.</p> <p>All residents and family members interviewed stated that activities are appropriate and varied and spoke positively about the programme.</p> <p>Five resident files reviewed identified that the individual activity plan is reviewed at the time of the care plan review.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plan is evaluated at least six-monthly or earlier if there is a change in health status. There is at least a three-monthly review by the GP. All changes in health status are documented and followed up. Care plan evaluations were resident-focused, evaluated resident progress and signed by a registered nurse. 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.</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 delivery.</p>	<p>FA</p>	<p>Elloughton has two sluice rooms – one in the new wing and one in the existing area which was replaced during the building process. Both sluice rooms have a sanitiser and appropriate personal protective equipment available. Both sluice rooms have a keypad lock. The previous shortfall has been addressed. Chemicals are safely stored in cleaner's rooms and all chemicals sighted were labelled with the manufacturer's label. Material data sheets are available for all chemicals.</p>
<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>	<p>FA</p>	<p>Since the previous partial provisional audit, the new wing and corridors that join the new and old wings have been completed and furnished. Handrails have been installed. A certificate of public use was issued on 9 January 2017 and a current building warrant of fitness is posted in a visible location for the rest of the building (expiry 1 May 2017). Outdoor areas have been landscaped and planted. Electrical equipment has been tested and tagged where it is more than one year old and medical equipment has been calibrated and/or serviced. The hot water is monitored monthly by the maintenance person and the temperature is adjusted and rechecked</p>

		if it is outside acceptable limits. The shortfalls identified at the previous partial provisional audit have been addressed.
<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	The new laundry has been completed and all equipment installed. Dedicated laundry staff provide the laundry system and resident and family satisfaction with cleaning and laundry processes is monitored. Cleaning and laundry are monitored through the internal auditing system. Chemicals in the laundry are safely stored and the area is a staff only area. The shortfall identified in the previous partial provisional audit has been addressed.
<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	The updated fire evacuation scheme was approved by the New Zealand Fire Service on 27 September 2016 and fire drills have been held to ensure staff familiarity with the plan. The call bell system is now operational in all areas. Call bells that are activated are displayed on panels throughout the facility, with an escalation system that includes an email to the manager if a call bell is not answered within five minutes. The shortfalls identified in these areas in the partial provisional audit have been addressed.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory, skin and infections that do not require antibiotics. The data is analysed in detail by the clinical manager to ensure any opportunities for improvement and trends are identified and acted on. This data is reported to the facility meetings. The service submits data monthly to Radius head office where benchmarking is completed. There have been no outbreaks since the previous audit.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The use of restraint is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked. There is a regional restraint group at the organisational level and a restraint group at the facility where restraint is reviewed.</p> <p>There was one resident with an enabler in the form of bed rails. These were requested by the resident. The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of the file of the resident using an enabler.</p> <p>There were two residents using restraints.</p>
<p>Standard 2.2.3: Safe Restraint Use</p>	FA	Restraint monitoring is completed on the electronic resident database. The

Services use restraint safely		database alerts staff when monitoring is due. The two residents with restraint had monitoring completed in the database that demonstrated at least two-hourly monitoring and any interventions completed at the time monitoring occurred. The previous shortfall from the certification audit has been addressed.
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## 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>When a service shortfall is identified through the internal auditing process, a corrective action plan is developed to ensure the issue is rectified. Corrective action plans developed from the internal auditing process sighted had been implemented and signed off as completed. The clinical manager develops comprehensive action plans when analysis of data reveals unwanted trends. The 2016 satisfaction survey demonstrated a decline in satisfaction with some specific areas presenting room for improvement (noting that the return rate was low), but no corrective action plan was developed to address the survey results.</p>	<p>No corrective action plan was developed to address the issues identified as requiring improvement in the annual satisfaction survey.</p>	<p>Ensure a corrective action plan is developed and implemented whenever service shortfalls are identified.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p>	PA Low	<p>Radius has a standard orientation programme that is specific to each role</p>	<p>The lack of facility specific training and the failure to provide a</p>	<p>Ensure that all staff receive a comprehensive</p>

<p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>		<p>and relies on a buddy system where experienced staff 'buddy' inexperienced staff to ensure they are orientated to residents needs and organisational systems. All staff employed have completed this programme. This is satisfactory when inexperienced staff are working alongside a majority of staff who are experienced and familiar with routines and resident's individual needs and idiosyncrasies.</p> <p>The opening of the new wing and a moderate turnover of existing staff meant that there were insufficient experienced staff to allow the 'buddy system' to effectively orientate staff employed since the previous audit. To address this, the service had intended to provide a comprehensive training/orientation day to inexperienced staff being employed to staff the new wing, prior to occupation. However, the closing of the DHB aged care hospital and the timing of the Christmas period meant staff commenced employment in small groups and a comprehensive orientation training programme was not provided for most staff. Only eight of the 21 staff employed since the previous audit completed the extended one day orientation. The previous shortfall has not been addressed.</p>	<p>comprehensive orientation day to new staff has resulted in insufficient staff with the required knowledge to provide a safe and effective service since December 2016, as reported by staff and residents interviewed and demonstrated in orientation records. As most of these staff have now worked at the service in excess of two months the risk is assessed as low. Also note, the majority of newly appointed staff had extensive experience and competency in health care.</p>	<p>orientation/training package to ensure that sufficient skilled staff are available to meet resident's needs.</p> <p>30 days</p>
<p>Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and</p>	<p>PA Low</p>	<p>Elloughton Gardens has a large new commercial kitchen which was clean on the day of the audit. Kitchen staff ensure and monitor that food served to residents is at a safe temperature and that all food</p>	<p>Temperatures have not been monitored for the fridges in the two kitchenettes, where residents own food is stored.</p>	<p>Ensure temperatures are monitored for all fridges throughout the facility.</p>

disposal comply with current legislation, and guidelines.		stored in the kitchen is stored at safe temperatures. Confusion around responsibility for monitoring the temperatures of fridges in the kitchenettes has meant these have not been monitored.		90 days
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## Specific results for criterion where a continuous improvement has been recorded

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

No data to display
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End of the report.