# Radius Residential Care Limited - Radius St Helena's Care Centre

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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 St Helena's Care Centre

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

**Dates of audit:** Start date: 19 June 2017 End date: 20 June 2017

**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:** 52

# 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

Radius St Helena’s is owned and operated by Radius Residential Care Limited. The service provides care for up to 52 residents requiring rest home or hospital level care. On the day of the audit, there were 52 residents. An enrolled nurse, with experience in aged care management, manages the service. A Radius regional manager and a clinical nurse manager support her. Residents and relatives interviewed spoke positively about the service provided.

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

This audit has identified areas for improvement around staff training, documentation of interventions in care plans and documentation of evaluations of previous care plans.

## 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. |

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers’ Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code. Personal privacy and values of residents are respected. There is an established Māori health plan in place. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends can visit residents at times that meet their needs. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

## 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. |

Services are planned, coordinated, and are appropriate to the needs of the residents. A facility manager and clinical nurse manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded. Corrective actions are implemented and evaluated where opportunities for improvements are identified. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. There is an annual education and training plan in place. Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

## 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. |

Primarily the facility manager and clinical manager manage entry to the service. There is comprehensive service information available. A registered nurse completes initial assessments. The registered nurses complete care plans. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process.

Each resident has access to individual, group and small group activity programmes that meets the recreational needs of the residents.

Medication is managed in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Medications are stored, prescribed and administered in line with appropriate guidelines and regulations. General practitioners review residents at least three-monthly or more frequently if needed. Meals are prepared off site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options can 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. |  | Standards applicable to this service fully attained. |

The building has a current warrant of fitness and emergency evacuation plan. There is an approved evacuation scheme and emergency supplies for at least three days. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and have ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are lounge and dining areas in the facility. The internal areas can be ventilated and heated. The outdoor areas provide seating and shade. Cleaning and maintenance staff are providing appropriate services.

There is an approved evacuation scheme and emergency supplies for three litres per day for three days per resident. There is a minimum of one first aid trained staff member on every shift.

## 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. |

The service has appropriate procedures and documents implemented for the safe assessment, planning, monitoring and review of restraint and enablers. During the audit, there were two residents using three restraints and no residents using enablers. Staff receive education and training in restraint minimisation.

## 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.

## 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 | 47 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 98 | 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)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Radius St Helena’s policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers’ Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with eight care staff (four healthcare assistants (HCA’s), three registered nurses (RN) and one activities coordinator) confirmed their understanding of the Code. Nine residents (six rest home and three hospital level) and one relative (hospital level) interviewed confirmed that staff respect privacy and support residents in making choices. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. 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 the family member identified that the service actively involves them in decisions that affect their relative’s lives.  Eight of eight resident files sampled had a signed admission agreement and consents. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files include information on residents’ family/whānau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care. Key people involved in the resident's life are documented in the care plans and there is a family communications/contact sheet in resident files where staff document when family have been contacted. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints. A complaints’ register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). No complaints were made in 2016 and one complaint received in 2017 year to date. A follow-up letter, investigation and outcome was documented. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | A tour of the premises confirmed there are areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents’ privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. An annual resident satisfaction survey was completed in October 2016 and the results showed that most respondents reported overall resident experience as being good or very good. Residents and relatives interviewed confirmed that staff treat residents with respect. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents interviewed confirmed their values and beliefs were considered. Interviews with HCAs described how choice is incorporated into resident cares. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The Māori health plan for the organisation references local Māori healthcare providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Māori consultation is available through the documented iwi links (Ngai Tahu) and Māori staff who are employed by the service. During the audit, there were no residents that identified as Māori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | An initial care-planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. One relative interviewed stated that residents’ values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Policies and procedures align with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. There is training for RNs from the local district health board (DHB). The service has introduced a centralised electronic database to improve standardisation of systems and improve the ability to meet compliance requirements. Outcomes for the service are monitored with benchmarking across all Radius facilities. Feedback is provided to staff via the various meetings and through graphs and notices on the noticeboard in the staff room. Registered nursing cover is provided 24 hours a day, seven days a week. A physiotherapist is available two hours a week. Registered nurses and HCAs were described by residents and family as being caring. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. Incident forms have a section to indicate if family have been informed (or not) of an accident/incident. All twelve incident reports reviewed met this requirement. The family member interviewed confirmed that they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Radius St Helena’s is part of the Radius Residential Care Group. St Helena’s cares for up to 52 residents requiring hospital and rest home level care. All rooms can be used for either hospital or rest home level care. On the day of the audit, there were 31 rest home level residents including one resident on long-term support chronic health conditions (LTSCHC) contract and 21 hospital residents including one resident on a LTSCHC contract.  The facility manager is a non-practicing enrolled nurse (EN) and has been in the role since February 2015. She has managed in aged care services for over 20 years. She is supported by a clinical nurse manager, who has been in the position for four years and has been at Radius St Helena’s for five years. The regional manager supports the facility manager in the management role and was present during the days of the audit. The facility manager has completed more than eight hours of training annually, relating to the management of a hospital.  The Radius St Helena’s business plan April 2017 to March 2018 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 is in place. Quarterly reviews are undertaken to report on achievements towards meeting business goals. The manager reports monthly to the regional manager on a range of operational matters in relation to Radius St Helena’s including strategic and operational issues, incidents and accidents, complaints, health and safety. |
| 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 | The clinical nurse manager covers during the temporary absence of the facility manager. The regional manager or facility managers of other Radius facilities are also available for support. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the managers reflected staff involvement in quality and risk management processes. Resident meetings are bi-monthly. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff.  The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The clinical nurse managers group with input from facility staff reviews the service’s policies at a national level, every two years. Clinical guidelines are in place to assist care staff. The quality-monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflected actions being implemented and signed off when completed.  Health and safety policies are implemented and monitored by the health and safety committee. The health and safety representative (maintenance person) interviewed confirmed his understanding of health and safety processes including recent law changes. He completed the external health and safety training 18 August 2016. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Radius has achieved tertiary level ACC Workplace Safety Management Practice. Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions. |
| 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 incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident forms are completed for each incident/accident with immediate action noted and any follow-up action required. A review of 12 incident forms identified that forms are fully completed and include follow-up by a RN. Neurological observations are carried out two-hourly for any suspected injury to the head. The facility manager and regional manager could identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. Two norovirus outbreaks in October 2016 and March 2017 were reported to public health. |
| 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. | PA Low | Human resources policies include recruitment, selection, orientation and staff training and development. Seven staff files reviewed (one clinical nurse manager, two RNs, three HCAs and one kitchen manager) included a comprehensive recruitment process which included reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals. A register of RN staff and other health practitioner practising certificates is maintained.  The orientation programme provides new staff with relevant information for safe work practice. Staff are required to complete written core competencies during their induction. These competencies are repeated annually. There is an annual education and training plan in place but not all required training has been completed. There is an attendance register for each training session and an individual staff member record of training which demonstrate that education attendance is low. Registered nurses are supported to maintain their professional competency. Five of the seven RNs have completed their 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 | A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. There is a FTE facility manager and FTE clinical nurse manager who work from Monday to Friday and are on call 24/7. There is a minimum of one RN on site at any time. There is one RN on duty on the morning shift, one on the afternoon shift and one on the night shift. The RNs are supported by adequate numbers of HCAs. There are seven HCAs on duty on the morning shift, five HCAs on the afternoon shift and two HCAs on the night shift. Staff working on the days of the audit were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and a family member interviewed report there are sufficient staff numbers. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The electronic resident files were 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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access and there are appropriate security and back-up procedures for the electronic database. |
| 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/registered nurse (RN) 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 facility 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. The relative 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. | FA | The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Registered nurses are responsible for the administration of medications and they complete an annual medication competency and attend medication education annually. Medication prescribed is signed as administered on the pharmacy generated signing chart. The facility uses a robotic sachet system for medications. The RN on duty reconciles the delivery and documents this on the signing sheet. There were five residents self-medicating (one hospital and four rest home) on the day of audit and all had a current competency assessment. Standing orders are not used. Medical practitioners write medication charts correctly and there was evidence of one to three monthly reviews by the GP. All 16 medication charts reviewed had photo identification and allergy status identified. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Meals are prepared and cooked by an external contractor in an off-site commercial kitchen. Meal temperatures are checked on arrival and transferred to bain maries where kitchenhands serve meals from the facility kitchen.  A food services manual is in place to guide staff. The kitchen follows a rotating seasonal menu, which has been reviewed by the company dietitian. A resident nutritional profile is developed for each resident on admission and is provided to the kitchen. The kitchen is notified of any dietary changes as confirmed by registered nurses. A special meal was delivered for one resident with a recent dietary change. Resident likes, dislikes, dietary preferences, modified and special diets are accommodated. There is special equipment available for residents if required.  The temperatures of refrigerators and cooked foods are monitored and recorded. All breakfast food is stored appropriately and dated. Residents and the family members interviewed were satisfied 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 reasons for declining service entry to potential residents should this occur and communicates this decision to potential 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. | FA | All appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. Appropriate assessment tools (InterRAI and those in the electronic database) were completed and assessments were reviewed at least six-monthly or when there was a change to a resident’s health condition in files sampled. Care plans are developed based on the outcomes of assessments (link 1.3.5.2). |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Five of eight long-term care plans reviewed in the electronic database described in detail, the support required to meet the resident’s goals and needs and identified allied health involvement under a comprehensive range of headings. The electronic assessments automatically generate interventions for each identified issue and these had been individualised to the individual resident’s requirements. Residents and their family/whānau are involved in the care planning and review process. Short-term care plans are in use for changes in health status. These are also documented in the electronic database. Staff interviewed reported they found the plans easy to access and follow. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Registered nurses (RNs), (including the clinical nurse manager) and healthcare assistants follow the detailed and regularly updated care plans (link 1.3.5.2) and report progress against the care plan each shift. When a resident’s condition changes, the RN initiates a GP, NP or nurse specialist consultation or referral, for example to the district nurse. 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.  Electronic wound assessments, monitoring and wound management plans are in place for residents with wounds including one venous ulcer and one diabetic ulcer, which are being appropriately managed.  Care plan interventions including intentional rounding also used for turning charts, food and fluid charts demonstrate interventions to meet resident’s needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | An activities person is employed fulltime and has been with the service for 12 years. There are volunteers involved in the activity programme including entertainers, church groups, RSA visits and one-on-one time with residents. Exercise sessions are provided in a variety of forms to maintain interest and physical well-being for all groups of residents. The programme has allocated one-on-one time for hospital residents and for those who choose not to participate in the group activities. Activities and entertainment occur in the main lounge and the smaller lounge. Group activities reflect ordinary patterns of life such as baking, library books, board games, bowls, current affairs and arts and crafts. Activities are flexible to meet the needs and wants of residents on different days. Outings into the community, to concerts and places of interest are planned. Special events are celebrated.  All resident files sampled had a recent electronic activity plan within the care plan and this had been evaluated at least six-monthly when the care plan was evaluated except prior to the transfer to electronic plans (link 1.3.8.2). Residents and families interviewed commented positively on the activity programme. Residents and families provide feedback on the activities through surveys, resident meetings and the six-monthly MDT reviews. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | The registered nurses evaluate all initial care plans within three weeks of admission. In files reviewed the long-term care plan was evaluated at least six-monthly or earlier if there is a change in health status, except for the six months immediately prior to the audit. Where progress was different from expected, the service had responded by initiating changes to the care plan. Short-term care plans are used for acute issues. These were not always evaluated. All changes in health status are documented and followed up. An RN had signed care plan reviews. |
| 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 reassessed. Examples of close liaison with dietitians, hospice, physiotherapist, mental health staff and social workers were sighted in resident files reviewed. |
| 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 datasheets are available. The two sluice rooms (one each wing) have personal protective clothing readily 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 that expires 1 July 2018. The building has several 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. Essential contractors are available 24 hours. Hot water temperatures are monitored monthly and are maintained between 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. Residents have access to external areas that have seating and shade. There is an outdoor designated resident smoking area. 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 Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All rooms at St Helena’s have an ensuite large enough to cater for resident’s needs. Additionally, there is an adequate number of communal toilets for residents. 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, including those required by hospital level residents. Residents are encouraged to personalise their bedrooms. Electric beds and ultra-low beds are used for hospital residents. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large main dining room adjacent to the kitchen. A smaller dining/lounge space is available for those residents who prefer to dine in a smaller group. A larger separate lounge area is available. There is safe and easy access to communal areas. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry including personal clothing is laundered off-site. There is a laundry area with facilities for hand washing of woollens, a sluice tub and commercial washing machine with a sluice cycle if needed. Cleaners have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility. The cleaners’ trolley was well equipped and stored in designated locked rooms when not in use.  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. | FA | There is an emergency management plan to guide staff in managing emergencies and disasters. There is a minimum of one first aid trained staff member on every shift. The facility has an approved fire evacuation plan. Fire evacuation drills take place every six months, with the last fire drill occurring on 12 May 2017. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and ongoing training. Civil defence supplies are checked six-monthly. Civil defence and emergency preparedness training is conducted annually, last occurring on 16 February 2017. There is sufficient water stored to ensure for three litres per day for three days per resident. There are alternative cooking facilities available with a gas barbeque and gas cooker. Electronic call bells were evident in resident’s rooms, lounge areas, and toilets/bathrooms. The facility is locked at night with doorbell access that is linked to the nurse call system. |
| 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 with heating that is adjustable in the resident’s rooms. The facility is well ventilated when required. All rooms have external windows that open, allowing plenty of natural sunlight. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Radius St Helena’s has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPIs. A registered nurse is the designated infection control nurse with support from the facility manager, clinical nurse manager and the quality management committee (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Radius infection control programme was last reviewed in July 2016. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | A registered nurse at Radius St Helena’s 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 procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are Radius infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | 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. This data is monitored and evaluated monthly and annually, and is provided to Radius head office. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality meetings and staff meetings and plans and interventions resulting from surveillance create improvements. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the acting facility manager. Outbreaks in October 2016 and March 2017 were appropriately managed. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. During the audit, there were two residents using three restraints (two bedrails and one chair brief) and no residents using an enabler. Staff training is in place around restraint minimisation. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical nurse manager) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. The restraint coordinator in partnership with the RNs, general practitioner (GP), resident and their family/whānau, undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Two hospital level residents where three restraints (two bedrails and one chair brief) were in use were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident and family and the GP. The use of restraint is linked to the residents’ care plans. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in the resident file where restraint was being used. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly as part of the restraint committee meeting. A review of two resident files identified that evaluations are up-to-date. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint minimisation programme is discussed and reviewed at the monthly restraint meetings, attended by the restraint coordinator (clinical nurse manager), RNs and HCAs. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme and staff/training. |

# 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 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is an annual education and training plan in place but not all required training has been provided. There is an attendance register for each training session and an individual staff member record of training. Records show low attendance at training sessions. | There is no documented evidence of skin integrity/wound care training for HCAs in the past 12 months. Staff attendance has been less than 50% at training/education sessions over the past 12 months. | Ensure all required trainings are provided for staff and that sufficient staff attend required training sessions.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | All residents have a care plan documented in the electronic resident database. These are automatically generated from the assessments completed in the electronic system. Five of the eight care plans sampled had interventions documented for all identified needs. Staff interviews and review of interventions implemented demonstrated that this is a documentation issue and resident care has not been impacted so the risk has been assessed as low. | Three of eight care plans sampled (two hospital and one rest home) did not have interventions documented for all identified needs. | Ensure that care plans document interventions for all identified needs.  90 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | In all eight long-term care plans sampled, regular six-monthly or more frequent evaluations of long-term care plans had occurred, with progress toward each goal being documented. In November 2016, the service implemented an electronic resident database and every resident had a new care plan completed in the database. The evaluations of the previous paper based care plan were not documented. Short-term care plans are used to document the interventions required for short-term and acute needs. Not all short-term care plans had been evaluated. | (i) Eight of eight long-term care plans were not evaluated in the six-months prior to the audit. (ii) The previous paper based short-term care plans had not been evaluated. | (i) Ensure progress toward desired outcomes is documented for each resident every six months. (ii) Ensure short-term care plans are evaluated.  90 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.