# Radius Residential Care Limited - Radius Hawthorne

## 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 Hawthorne

**Services audited:** Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Residential disability services - Physical

**Dates of audit:** Start date: 5 July 2017 End date: 6 July 2017

**Proposed changes to current services (if any):** A partial provisional was also completed that included verifying the service as suitable to provide rest home level of care for up to 10 residents.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 56

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Hawthorne is part of the Radius Residential Care Group. Hawthorne cares for residents requiring hospital (geriatric and medical and psychogeriatric) and residential disability (physical) level care. The facility can cater for up to 94 residents across two psychogeriatric units and two hospital units. On the day of the audit there were 56 residents.

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

A concurrent partial provisional audit was conducted that has assessed the service as suitable to provide rest home level care for up to 10 residents.

The facility manager commenced six weeks before the audit and is currently undergoing orientation. She is a registered nurse with many years of aged care management experience and is supported by an experienced Radius roving clinical nurse manager who has been supporting the service for five months, while a clinical nurse manager is being recruited, and the Radius regional manager.

Hawthorne has undergone a period of significant change with a change of manager, the resignation of the clinical nurse manager, a moderate to high staff turnover and the recent completion of a protracted rebuilding and repair project following the 2011 Christchurch earthquakes. Residents and families interviewed spoke positively about the services provided and the building upgrades. Staff described a sense of continued improvements and hope after a difficult period.

Improvements are required around registered nursing cover, staff training, the quality programme, timeliness of documentation, documentation of evaluations, staff medication competencies and documentation of resident allergies.

## Consumer rights

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| 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. |

Hawthorne practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights ‘the Code’ and copies of the code are displayed throughout the facility. There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. There are implemented policies at Hawthorne to protect residents from discrimination or harassment. There is an open disclosure and interpreter’s policy that staff understand. Family/friends can visit at any time and interviews verified ongoing involvement with community activity is supported. There is a complaints policy supporting practice and an up-to-date register. Staff interviews confirmed an understanding of the complaints process.

## Organisational management

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

Hawthorne is part of the Radius group and as such, there are organisational-wide processes to monitor performance. The service is managed by appropriately trained personnel and there is a suitable structure in place to oversee service delivery in the absence of the manager. There is an adverse event reporting system implemented at Hawthorne and monthly data collection is undertaken. There is a human resource manual to guide practice. Staff files were reviewed and all had a current appraisal and showed human resource practices are followed. There is a documented rationale for staffing the service. Staffing rosters were sighted and healthcare assistant staff on duty match needs of different shifts. Resident information is kept confidential and old records are archived.

## Continuum of service delivery

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

The residents’ records reviewed provide evidence that all residents have been assessed appropriately prior to admission to this facility by the needs assessment service coordinators. The residents’ needs, outcomes and/or goals have been identified in the assessments, and care plans are reviewed six-monthly or more often as required.

A visual inspection of the medication systems and the morning medication round evidenced compliance with respective legislative requirements, regulations and guidelines. There is evidence of the three-monthly medication reviews being completed by the general practitioners. These reviews are completed more frequently if required. The contracted pharmacist audits the medication records and controlled medications. The medication system is in the form of blister packs.

Food services are managed effectively. Meals are prepared on site. Nutritional guidelines and advice is available, which is appropriate for this service setting. The food service is managed by a contractor. The menu plans have been reviewed by a dietitian and are suitable for the elderly and/or disabled residents. The menus are clearly documented and displayed daily. The individual dietary needs are identified during the assessment process for each resident and choices are provided. Meals are provided at appropriate times of the day.

An activities programme is provided and enjoyed by the residents. Participation is encouraged but is voluntary. Activities are planned that are meaningful and the programme is developed and implemented to ensure the interests of residents are included. Community outings are arranged and entertainers are invited to participate in the programme. Special consideration is given to younger people when planning the activities programme.

## 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. |

Bedrooms provide single accommodation and 48 out of 94 bedrooms have ensuite shower and toilet facilities. Residents' rooms are large enough to allow for the safe use of mobility and lifting aids. The rooms in Sumner wing, which are proposed to be used for rest home level residents have individual ensuites, a small kitchenette and an external door and are suitable to meet the needs of rest home level residents.

There are a main lounge and dining area in each unit. Outdoor areas are available and seating and shading is provided in external areas. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry and emergency management, and these are known by staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of adequate sluice facilities, safe and hygienic storage of chemicals, cleaning equipment, and soiled linen. Protective equipment and clothing is provided and is used by staff. All laundry is contracted off-site. Cleaning and laundry systems include appropriate monitoring systems to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There are appropriate systems in place to ensure the physical environment is safe, and facilities are fit for their purpose.

Appropriate documentation including an approved evacuation plan, training including fire drills and first aid certificates for registered nurses and supplies including sufficient food and water for three days in an emergency are available.

## 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. |

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and an enablers’ register. There were four residents requiring restraints and four residents with identified enablers. Restraint assessments are based on information in the care plan, discussions with residents/relatives and on staff observations of residents. Staff are trained in restraint minimisation and restraint competencies are completed regularly. Restraint is reviewed for each individual at least three-monthly and as part of the multidisciplinary review. Multidisciplinary reviews include family/whānau.

## 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. |

Radius Hawthorne has an infection control programme that complies with current best practice. There is a dedicated infection control nurse who has a role description. The infection control programme is reviewed annually. Infection control education is provided at orientation and incorporated into the annual training programme. Training records were sighted. Education provided includes an evaluation of the session and content delivered. Records of all infections are kept and provided to head office for benchmarking.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 44 | 0 | 5 | 1 | 0 | 0 |
| **Criteria** | 0 | 94 | 0 | 6 | 1 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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).

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| **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 | There is an implemented code of rights policy and procedure. Discussions with seven healthcare assistants (four from the psychogeriatric units and three from the hospital) and five registered nurses (three from the psychogeriatric units and one enrolled nurse (who works in the hospital) and one activities coordinator identified their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights ‘the Code’ Interviews with ten residents from the hospital including two on young persons with disabilities contracts (YPD), two on long-term support – chronic health conditions (LTS – CHC) contracts and one funded by ACC) and seven relatives (four from the hospital and three from the psychogeriatric units) confirmed service is provided in line with the Code. |
| 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 | Policies and training support staff to provide care and support and enable residents to make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with healthcare assistants identify that consents are sought in the delivery of personal cares. Written consent includes the signed admission agreements. Eight resident files sampled (four from the hospital including two young persons with disabilities (YPD) and one ACC, and four from the psychogeriatric unit including one on a long-term support chronic health conditions), included consent for transporting, photographs and provision of care. All eight resident files reviewed included signed consent forms signed by the resident/family/whānau/EPOA. The advanced directives/resuscitation policy was implemented in the resident files reviewed. All advance directives are completed by the resident where able, the GP and discussion with family members is documented. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | There is an advocacy policy and procedure that includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and advocacy pamphlets are available at reception. Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.  The resident file includes information on resident’s family/whānau and chosen social networks.  Discussion with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The client information pack informs that visiting can occur at any reasonable time. Interviews with residents and relatives confirmed that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans. There is a family communications/contact sheet in resident files where staff document when family have been contacted.  The service has strong community support and engagement. Residents on the YPD contract are engaged in a range of diverse community activities including (but not limited to) attending a community day care centre.  Discussion with residents and relatives verified they are supported and encouraged to remain involved in the community and external groups. There are a number of ways Hawthorne supports ongoing access to community services, for example: RSA and community activities. Discussion with relatives indicated that they are encouraged to be involved with the service and care. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and procedure states that clients/family/whānau shall have access to a complaints system whereby they can express concern without prejudice and those concerns are addressed. Residents/family can lodge formal or informal complaints through verbal communication, written, resident meetings, and complaint forms or via suggestion box. Complaints information and forms are included in the information pack provided to residents and relatives at entry.  Interviews with residents and relatives demonstrated familiarity with the complaints procedure and they stated all concerns/complaints are addressed.  The complaints log/register includes date of incident, complainant, summary of complaint, and sign-off as complete. There have been five complaints in 2017 to date. All have documentation of full investigation and resolution including communication with complainants is documented for all complaints. One complainant accepted the offer to involve a health and disability advocate in the complaint process. The complaint was resolved to the satisfaction of the complainant. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service provides information to residents that includes the code of rights, complaints and advocacy information. Information is given to next of kin or EPOA to read to and/or discuss with the resident. Interviews with residents and relatives identified they are well informed about the code of rights.  The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet, advocacy and H&D Commission information. The 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 | The service has a philosophy that promotes quality of life and involves residents in decisions about their care, respects their rights and maintains privacy and individuality.  Interdenominational services are held weekly. Contact details of any spiritual/religious advisors are available to staff. Religious dietary requirements identified through assessment and care planning are met as required. Discussions with residents and relatives confirmed the staff are respectful and that their privacy is respected and that cultural and/or spiritual values and individual preferences are identified. Care plans reviewed identified specific individual likes and dislikes.  The abuse & neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Staff have completed training around this and could describe appropriate practices to prevent and identify any abuse or neglect.  Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There is a specific Māori Health care plan and a culturally safe care policy. Discussions with staff confirmed an understanding of the different cultural needs of residents and their whānau. There is a section in the assessment tool and care plan that includes spirituality, religion and culture, psycho-social needs and family and significant others. In addition, there is a Māori care plan available if the individual resident wishes. There were currently no Māori residents at Hawthorne. The service also utilises a local cultural advisor. He is a Kaumātua and has links to local iwi. |
| 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 | Care planning includes consideration of spiritual, psychological and social needs. Residents indicated that they are involved in the identification of spiritual religious and/or cultural beliefs. There are regular church services at Hawthorne. Relatives interviewed stated that they felt they were valued, consulted and kept informed. Family involvement is encouraged (e.g., invitation to facility functions).  Care plans reviewed included the residents’ social, spiritual, cultural and recreational needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There is a comprehensive and implemented discrimination and harassment policy in place. There is a staff policy in relation to gifts and gratuities and the management of external harassment. Residents interviewed informed they were not exposed to exploitation.  A staff employment handbook and orientation package includes a code of behaviour. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Interviews with staff informed an understanding of professional boundaries.  Healthcare assistants are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with healthcare assistants from the psychogeriatric unit could describe how they build a supportive relationship with each resident. Interviews with families from the psychogeriatric unit confirmed the staff assist to relieve anxiety. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Services are provided at Hawthorne that adhere to the Heath & Disability Services Standards (2008) and that all required legislation and guidelines are adhered to. The service has implemented policies and procedures to provide assurance it is adhering to relevant standards. Policies are reviewed and approved by the clinical management committee at an organisational level. The good practice policy supports staff in ensuring good practice is intrinsic to care delivery. The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility.  Staff are informed when external training is available and financial support is considered. There is support available for those wishing to pursue postgraduate qualifications (appropriate to the area of work). There is access to computer and internet resources and search engines.  There are implemented competencies for healthcare assistants, and registered nurses including restraint, manual handling, hand hygiene and fire safety, medication and syringe driver (for registered nurses). There are clear ethical and professional standards and boundaries within job descriptions. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure policy. Residents stated they were welcomed on entry and were given time and explanation about services and procedures.  Twelve incident reports were reviewed across the service. All recorded family notification where this was possible (one resident has no identified family or contact person). Relatives informed they are notified of any changes in their family member’s health status.  The residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.  The facility has an interpreter policy to guide staff in accessing interpreter services. There are no residents who currently require an interpreter. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit. One younger resident uses computer assisted communication. Staff interviewed were familiar with the use of this and were seen using it to communicate with the resident.  Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. The information pack is available in large print and advised that this can be read to residents. The information pack and admission agreement included payment for items not included in the services. A site-specific booklet; ‘Introduction to dementia unit’ provides information for family, friends and visitors to the facility. The enquiry pack along with a new resident’s handbook provides practical information for residents and their families. |
| 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 Hawthorne is a Radius aged care facility located in Christchurch. The facility is certified to provide hospital, psychogeriatric and residential physical disability care for up to 94 residents (forty-seven in the two psychogeriatric units and forty-seven in the hospital units). One bed is permanently funded as a respite bed.  Fifty-six residents were living at the facility during this audit – twenty-two at hospital level and thirty-four at psychogeriatric level. This included three residents on younger persons with disabilities contracts and one on an ACC funded contract, all receiving hospital level care and five residents on long-term support, chronic health conditions contracts – four receiving hospital level care and one receiving psychogeriatric level of care.  This audit has included a partial provisional audit that has assessed the service as suitable to provide rest home level care for up to 10 residents in Sumner wing.  The current business plan describes the vision, values and objectives of Radius Hawthorne, which includes a person-centred approach. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.  Annual goals are linked to the business plan and reflect regular reviews via regular meetings and monthly reports to the regional manager. The Radius senior management team, including the regional manager had identified a number of issues at the service prior to the audit and a facility wide corrective action plan had been developed and implemented to address these issues.  The new facility manager has been at the service for six weeks and is a registered nurse with many years’ experience in aged care management. The clinical nurse manager resigned in November 2016. The service is actively recruiting a suitable person for the role. Initially the role was covered by a senior registered nurse and since March 2017 a senior Radius roving clinical manager has filled the role.  The facility manager has maintained at least eight hours of professional development activities related to managing an aged care facility.  Partial provisional: The current business plan includes goals and actions to transition to providing rest home level care. |
| 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 | During the temporary absence of the manager, Hawthorne is managed by the clinical nurse manager with support from the regional manager. Radius has roving clinical managers and roving managers who can provide support during absences. A roving clinical nurse manager is currently filling the clinical nurse manager role.  A review of the documentation, policies and procedures and discussion with staff identified that the service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and dementia and promotes quality of life. |
| 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. | PA Moderate | There is an organisational quality/risk management plan that includes: clinical/care related risks, human resources, health and safety, environmental/service, financial as well as site-specific risks/goals identified for Hawthorne.  There are policies and procedures appropriate for service delivery. Policy manuals are reviewed two yearly. New/updated policies are sent from head office. New policies/procedures are put in the staff room with a signing sheet for staff to sign once they have read and understood the documentation.  Quality data including collection of monthly accident/incident and infection surveillance data, resident/relative surveys and internal audits are conducted and corrective action plans are developed and implemented when service shortfalls are identified. Quality data is benchmarked against other Radius facilities by head office. There was a lack of documented evidence of analysis of data at the service for trends. There are regular quality, restraint, registered staff and staff meetings but quality data and corrective action plans were not documented as discussed at these meetings. Resident/relative meetings are held bi-monthly. Meetings have been held in 2017 January, March and May. The 2016 resident/relative satisfaction survey did not have a high response rate. Surveys include young people with disabilities around issues relevant to this group.  There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The administrator is the identified health and safety coordinator and is supported by the maintenance person. Staff and contractors are orientated to health and safety issues and staff and the health and safety team identify and report hazards on hazard forms which are then eliminated or minimised and added to the regularly reviewed hazard register.  Falls prevention strategies for individual residents such as sensor mats, low beds, landing mats, specialised chairs and intentional rounding are implemented and were described by staff interviewed. |
| 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 | When an incident occurs the healthcare assistant (or staff discovering the incident) completes the form and the RN undertakes an initial assessment. The RN notifies family and GP as required. The clinical nurse manager collects incident reports daily and reviews both the incident and actions taken. Where the action taken is not considered to have been comprehensive, the clinical nurse manager will investigate and escalate to the facility manager. Twelve incident forms sampled evidenced detailed investigations and corrective action plans following incidents.  The staff interviewed could describe the process for management and reporting of incidents and accidents.  Accidents and incidents are collated on a monthly form and submitted to head office for benchmarking. Evidence of analysis of incidents was lacking (link 1.2.3.6).  Discussions with the service (regional manager and facility manager) confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. Notifications have been made around pressure injuries, an outbreak, a call bell system failure (the call bell system was in the process of replacement at the time of the audit) and on two occasions for a lack of sufficient RN cover in one area. |
| 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 | Ten staff files were reviewed – the administrator, four healthcare assistants, one activities coordinator, one cleaner and three registered nurses. All files reviewed had appropriate employment and human resource documentation including interview and reference check documentation, employment contracts and job descriptions. The eight files for staff who had been employed longer than one year had an annual performance appraisal. There is a register for staff competencies that shows all competencies are now current (link 1.3.12.3). Practising certificates were sighted for: registered nurses, the enrolled nurse, GPs, physiotherapist, pharmacy, podiatrist and dietitian.  The organisation has a staff orientation policy. Hawthorne has an orientation programme that is specific to worker type. The new staff member is buddied for three shifts with an experienced healthcare assistant (HCA). Staff interviewed confirmed that all staff employed have an orientation period and that this is extended if required. For the year prior to the audit, orientation paperwork had not been completed, or for staff who confirmed this had been completed, it was not able to be located. A Radius roving manager has been seconded to Hawthorne to focus on addressing staff training issues including orientation. Over the weeks prior to the audit every staff member employed in the last year has had another orientation completed and all documentation associated with this completed. All files sampled had completed orientations. No finding has been made as the issue had been identified and addressed prior to the audit.  The service has an internal training programme directed by head office. However, this had not been fully implemented for the last year. The roving manager has provided training sessions around many required topics in the past year and staff reported being grateful for the focus on education. Not all required training has yet been completed.  The roving manager has also spent time supporting staff to complete the required dementia standards. All staff who work in the psychogeriatric units have now commenced the required training with three staff having completed this within one month. There are 28 healthcare assistants in the psychogeriatric units. Eleven of these have completed the required dementia standards and the other 17 have commenced the training. Not all staff who have been employed for longer than one year have completed the required standards. All activities staff have completed dementia training. Staff training has included sessions on individuality and promoting independence to ensure the needs of younger residents are met.  Partial provisional: Staff employed have the skills to support rest home level residents. The recent training around individuality and promoting independence will support staff to support the needs of rest home level residents. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Low | There is an acuity and clinical staffing ratio policy in place that includes a documented rationale for staffing the service. The facility manager and roving clinical manager, both registered nurses, work full time and share on-call responsibilities.  The service is divided into four units and occupancy is currently low. Staffing in each unit is as follows:  Brunner (psychogeriatric unit). Currently 16 of a potential 20 residents. There is a registered nurse on duty 24 hours per day. On morning shifts two healthcare assistants work a full shift and two a short shift. On afternoon shifts two healthcare assistants work a full shift and two work a short shift. On night shift, there is one healthcare assistant.  Victoria (psychogeriatric unit). Currently 18 of a potential 27 residents. There is a registered nurse on duty 24 hours per day. On morning shifts two healthcare assistants work a full shift and two a short shift. On afternoon shifts two healthcare assistants work a full shift and two work a short shift. On night shift, there is one healthcare assistant.  Brunner and Victoria share a diversional therapist from 9 am to 5 pm, Monday to Friday and 10 am to 3 pm on the weekends.  Sumner and Wanaka/Tekapo share registered staff. There is a registered staff member on duty 24 hours per day. This includes a full time enrolled nurse who works morning shifts. When the enrolled nurse is on duty Monday to Friday the clinical manager oversees her. There is no registered nurse cover in the hospital unit when the enrolled nurse is on duty in the weekends. Sumner and Wanaka/Tekapo are adjacent to each other.  Sumner (hospital unit). Currently 14 of a potential 27 residents. On morning shifts two healthcare assistants work a full shift and one works a short shift, on afternoon shifts two healthcare assistants work a full shift and one works a short shift and there is one healthcare assistant on night shift.  Wanaka/Tekapo (hospital unit). Currently 8 of a potential 20 residents. One healthcare assistant works a full morning shift and one a short shift and one works a full afternoon and one a short shift. There is one healthcare assistant on duty overnight. Staff from Sumner support Wanaka/Tekapo staff if required.  Staff interviewed stated that there is adequate staffing to manage their workload, especially while occupancy is currently low. When staff are absent and a replacement cannot be found from the current staff, agency staff are used.  There is a physiotherapist who works two to three hours per week and a physiotherapy assistant works 28 hours per week.  There are three GPs and each visit weekly for two hours and as required.  Residents and relatives interviewed confirmed that there are sufficient staff on-site at all times and staff are approachable and in their opinion, competent and friendly.  Partial provisional: The current staffing in Sumner unit is sufficient to meet the needs of rest home level residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents’ individual record and service register. These are paper based files.  Information containing 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. Informed consent is obtained from residents/family/whānau on admission, for permission to display the resident’s name and taking of photographs.  Entries in resident files sampled were legible, dated and signed by the relevant caregiver or RN including designation. All resident records contain the name of resident and the person completing the form/entry.  Individual resident files demonstrated service integration that also contains GP notes and the allied health professionals and specialists records if applicable. |
| 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 | NASC assessments are required for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident’s admission regarding the resident’s level of care requirements. There is a comprehensive information pack provided to all residents and their families for the hospital and psychogeriatric care. Residents and family members interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Eight residents’ files (four from the hospital including two younger persons with disabilities and one on an ACC contract and four from the psychogeriatric unit including one on a LTS - CHC contract) were reviewed. All files sampled (except the ACC resident) had NASC approval and all had signed service agreements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record is kept and a copy is kept on the resident’s file. This was sighted in one resident file. All relevant information is documented and communicated to the receiving health provider or service via the yellow envelope system. A transfer form accompanies residents to receiving facilities. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | There are policies and processes that describe medication management that align with accepted guidelines. Medications are checked against the doctor's medication profile on arrival from the pharmacy by a RN. Any errors by the pharmacy are regarded as an incident.  Designated staff are listed on the medication competency register. Staff responsible for medication administration are either registered or enrolled nurses and they complete an annual medication competency or when they contribute to a medication error. Not all staff had medication competencies completed at orientation. Syringe driver competency and education was completed in June 2014.  Resident medication charts are identified with demographic details and photographs. The fridge where medications are kept, has a weekly temperature check. Allergies or nil known are not identified on all sampled medication records. The service documents adverse reactions and errors on incident/accident forms.  The medication round was observed at breakfast time across two units; all practice was appropriate.  There is a policy and process that describes self-administered medicines. There is currently one resident who self-administers one of his night medications. The resident’s competency is checked three-monthly and a record signed by the GP is kept on file  Sixteen medication charts (eight from the hospital; eight from the psychogeriatric unit) were reviewed and demonstrated medication profiles are legible, up-to-date and reviewed at least three-monthly by the GPs. All as required medication charted included an indication for use. Medication signing sheets were signed following administration.  Partial provisional:  The currently implemented medication system is satisfactory to meet the needs of rest home level residents. |
| 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 | All food is cooked on-site and staff are employed by an external contractor who oversees all functions and provision of food. The kitchen also provides food services for two other facilities in Christchurch. The chef and kitchen staff stated that all staff have been trained in safe food handling. Fridge/freezer and dishwasher temperatures are monitored.  The service has a large workable kitchen. The kitchen and the equipment are well maintained. Meals are plated in the kitchen and delivered to wings via a hot box system to maintain correct food temperatures. The winter and summer menus are varied and developed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed. At interview, the chef described that the RN completes each resident`s nutritional profile on admission with the aid of the resident and family. Special diets are catered for and documented in the kitchen. Food safety information and a kitchen manual are available in the kitchen. Food served on the day of audit was hot and well presented.  The service encourages residents to express their likes and dislikes. The residents interviewed spoke highly about meals provided and they all stated that staff ask them about their food preferences. Equipment is available on an ‘as needed’ basis. Residents requiring extra support to eat and drink are assisted, this was observed during lunch.  The service has introduced a new electronic system ‘Jolt’ which records delivery temperatures, temperatures of prepared food in the bain marie and in both the fridge and freezers to ensure it is disposed of when use by date expires. Fridge/freezer temperatures are checked daily and recorded on ‘Jolt’. Food in the fridge and chiller were covered and dated. The kitchen is clean and all food is stored off the floor. Chemicals are locked away.  Food audits are carried out as per the yearly audit schedule.  Partial provisional:  The current food service is satisfactory to accommodate all rest home resident dietary requirements. |
| 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 | There is a declining entry section in the admission procedure. The service documents the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | A comprehensive initial nursing assessment is completed within 24 hours of admission and the care plan is completed (link 1.3.3.3). Personal needs, outcomes and goals of residents are identified. Resident files sampled demonstrated that a range of assessment tools were completed in resident files and reviewed at least six monthly including (but not limited to); falls, pressure areas and continence. All files sampled for residents under the ARHSS and ARCC contracts had a current interRAI assessment. Nutrition and pain are assessed on admission and as needed and weights and general observations are monitored on a weekly to monthly basis dependant on needs. Assessments are conducted in an appropriate and private manner.  Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Resident interviews (ten from the hospital), and seven family members (four from the hospital, three from the psychogeriatric unit), stated they were informed and involved in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans are individually developed with the resident, and family/whānau involvement is included where appropriate. All eight care plans reviewed were evidenced to be up-to-date. Goals and outcomes are identified and agreed and how care is to be delivered is explained.  All files sampled have an individualised long-term care plan that covers all areas of need identified. Areas covered in the eight resident files sampled include (but are not limited to): behaviour, social and emotional needs, cultural needs, falls risk, ADLs, nutrition and social needs. Service delivery plans demonstrated service integration. Assessments and care plans are comprehensive and include input from allied health including gerontology specialists, dietitians, oncology, DHB nurse specialist, physiotherapy and podiatry. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The service provides services for residents requiring hospital level care, psychogeriatric and younger people with disabilities. Care plans are completed comprehensively.  In files sampled wound care plans, infection control plans, diabetes specific plans, nutrition management, fluid balance management plans and pain management plans were evident. Six of seven LTCPs requiring review (one psychogeriatric resident had not been at the facility long enough to require review) evidenced at least six-monthly care plan reviews (link 1.3.3.3). The use of short-term care plans was evident. The care being provided is consistent with the needs of residents, this is evidenced by discussions with residents, family and staff. The GP interviewed stated the facility applied changes of care advice immediately and was highly complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission and residents’ primary care is provided by their own GP.  There is evidence of referrals to specialist services such as podiatry, physiotherapy, nutritional, district nurses and gerontology nurse specialist. There is also evidence of community contact.  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. Specialist continence advice is available as needed and this could be described. Wound assessment and wound management plans were in place for ten residents with wounds. Three residents have pressure areas. All wounds have been assessed, reviewed and managed within the stated timeframes. On interview, the five RNs and the clinical nurse leader stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required. There is evidence in files of the wound specialist referrals. |
| 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 | The hospital unit has a full time (37.5 hours per week) diversional therapist working Monday to Friday, each psychogeriatric unit has a dedicated diversional therapist (one working 27.5 hours and the other 20 hours per week) covering Monday to Friday and weekends. All recreation/activities assessments and reviews are up-to-date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge of each unit. 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. Four of the eight resident files reviewed also contained a behaviour section in the registered nurse written care plan that describes individual behaviours and any de-escalating techniques that are appropriate. The two diversional therapists interviewed described participating in discussions with the RNs in preparation of this aspect of the care plan. The diversional therapists interviewed also stated that they participate in annual multidisciplinary meetings and conduct monthly residents’ meetings for the younger residents where activities are planned to meet the needs of these residents. Younger person specific activities include (but are not limited to), involvement with local community, accompanying and assisting staff on meals on wheels deliveries and accompanying maintenance staff to purchase supplies and tools. Personalised exercise equipment is available for a younger person with disabilities.  Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Activities include entertainers, crafts, exercise, music/sing-a-long, bingo movies, men’s club, outings, balloon tennis and baking. There are also visits from community groups. There is a theme allocated monthly and activities are planned around the theme.  All seven family members interviewed (two from the hospital, four from the psychogeriatric unit), stated that activities are appropriate and varied enough for the residents. All ten hospital residents interviewed, stated they were happy with the activities available and are given a choice regarding attendance.  Partial provisional:  The activities staff currently provide separate activities for higher functioning residents and have the resources to expand further for rest home level residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | There is a three-monthly review by the GP. There was documented evidence that RN evaluations were current and completed for seven of seven care plans who required review (one resident had been at the facility less than six months – link 1.3.3.3), however the reviews for some over the last two years frequently stated, “No changes”. GPs review residents’ medication at least three-monthly or when requested if issues arise or health status changes. |
| 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 forms and documentation are maintained on resident files.  There is information available pre-admission and in the admission documentation on the health and disability code of rights, advocacy, health practitioners code of conduct and informed consent. Follow-up occurs as appropriate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents and forms are completed by staff. There are no incident/accident reports reviewed involving waste, infectious material, body substances or hazardous substances.  There is an emergency plan to respond to significant waste or hazardous substance management.  All chemicals sighted were appropriately stored in locked areas. Chemicals are supplied by Ecolab and appropriately labelled. Sufficient gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn.  Partial provisional:  The current systems for managing waste and hazardous substances is satisfactory to meet the needs of rest home level residents. |
| 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 holds a current warrant of fitness, which expires in January 2018. Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted by an external fire safety contractor. When an issue requiring maintenance is noticed the maintenance person deals with the issue on the same day. In most cases the issue can be repaired or resolved on the same day. The maintenance person is available from Monday to Friday. External contractors are engaged to complete work as required. A sample of hot water temperatures are taken monthly and these are maintained at (or just below) 45 degrees. When temperatures were observed to be outside acceptable range, corrective actions were initiated and corrected.  The facility's amenities, fixtures, equipment and furniture are appropriate for the level of service contracted. The facility has recently completed a refurbishment and rebuilding programme. There is sufficient space to allow residents to move around the facility freely. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Residents’ bedrooms throughout the facility have resident's own personal belongings displayed. External areas and garden areas surrounding the facility are well maintained. Level paths to the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained.  The two psychogeriatric units are secure and each has an attractive secure garden.  Partial provisional:  Each room in the Sumner wing has sliding doors opening to the garden, a built-in kitchenette and full ensuites and are suitable for rest home level residents. |
| 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 | There are an adequate number of toilets and showers in each unit. Each bathroom has a hand basin and communal toilets have hand washing and drying facilities. There are soap dispensers in all bathrooms. There are separate staff/visitors’ toilets. There is signage to promote effective hand washing techniques in the staff and visitors’ toilet. There are alcogel pumps available throughout the facility. The facility has a specially designed bathroom suited for bath trolley use. The facility was clean, well presented and odour free  Partial provisional:  All individual rooms in the Sumner wing have full ensuite facilities and are satisfactory to meet the needs of rest home level residents. |
| 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 | There is adequate space in all bedrooms for residents and staff. Healthcare assistants confirmed they could move freely to provide cares and there is enough space to move mobility equipment safely. Doorways into residents' rooms and communal areas are wide enough for wheelchair, trolley and bed access. Ten residents interviewed stated they are happy with their rooms  Partial provisional:  The large refurbished rooms in the Sumner wing are adequate for rest home level occupancy. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service has a main lounge and dining area in each unit. There are smaller lounge areas within the facility. Residents were seen to be moving freely throughout the facility. Residents can move freely from their bedrooms to communal rooms and the outside. Internal and external doorways are level with pavements, which allows wheelchair access. Activities occur in the main lounges and residents can access their rooms for privacy when required. Residents stated that they are happy with the layout of the hospital.  Partial provisional:  The Sumner wing has a large sunny lounge and attached dining room area with communal kitchen and outdoor access and is satisfactory to meet the needs of rest home level residents. |
| 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 | There are cleaning policies and processes. Cleaning audits occurred in March 2017 with 96% compliance. There are sluice rooms in each unit for the disposal of soiled water or waste. On the day of the audit, these were locked when unattended.  The cleaning rooms are designated areas and clearly labelled. All laundry is done off-site.  Partial provisional:  The Sumner wing contains a sluice room and access to a locked cleaning room for storage of chemicals and cleaning trolleys when not in use, thereby able to meet the needs of rest home level residents. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Fire evacuation practice documentation was sighted. 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. Emergency equipment is available. A civil defence cupboard is available (sighted). There are spare blankets and alternative cooking methods if required (viewed). There is sufficient water stored in a tank to ensure for three litres per day for three days per resident.  First aid training has been provided for registered nurses and there is at least one staff member on duty at all times with a first aid certificate. The NZ Fire Service approved the evacuation scheme on 31 August 2010.  There are call bells in all communal areas, toilets, bathrooms and residents’ rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign-in when visiting the facility. The call bell system is in the process of being upgraded.  Partial provisional:  The emergency management systems in place are satisfactory to meet the needs of rest home level residents. |
| 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 resident rooms are appropriately heated and ventilated. The facility has thermostatically controlled wall mounted heaters in each resident room and heat pumps in communal areas. All bedrooms and communal areas have at least one external window. The indoor temperatures were pleasant and warm.  Partial provisional:  All rooms in the Sumner wing are fitted with individual thermostatically controlled wall mounted heaters. The corridors and communal areas are heated by heat pumps and are suitable to meet the needs of rest home level residents. |
| 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 Hawthorne 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 facility manager (registered nurse) is the designated infection control nurse with support from the roving clinical manager and the quality management committee (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Radius infection control programme was last reviewed in July 2016.  Partial provisional:  The current infection control programme is suitable to meet the needs of rest home level residents. |
| 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 | The facility manager is now the IC nurse and is aware of the need to analyse data and the reasons behind this. The IC nurse receives ongoing education and completed on-line training in July 2017. She is booked to complete Bug Control training. In the event of the IC nurse requiring advice this is available through the GP, the DHB resource person or Bug Control. |
| 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 | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. The infection control policies link to other documentation and uses references where appropriate.  Infection control policies are reviewed as part of the policy review process by Radius. Input is sought from facilities when reviewing policies. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The IC nurse ensures training is provided to staff. Informal education is also provided - availability of education was confirmed by healthcare assistants interviewed.  The orientation package includes specific training around hand washing and standard precautions. Training on infection control has been provided in 2017. Hand washing is an annual competency.  Resident education is expected to occur as part of providing daily cares. |
| 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 | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme. The service submits data monthly to Radius head office where benchmarking is completed.  Infections are collated monthly - including urinary tract, upper respiratory and skin. Infections are collated monthly - including urinary tract, upper respiratory and skin. This data is not analysed for trends (link 1.2.3.6) but the raw data is reported to the quality meetings and to RN meetings and staff meetings.  An outbreak in September 2016 appeared to have been appropriately managed. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service philosophy around restraint is that it is used as an intervention that requires a rationale and 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 the registered nurses constitute a restraint group at the facility where restraint is reviewed.  There are four hospital level residents with enablers in the form of bedsides and lap belts. Review of files for residents with enablers and interviews with two residents confirmed that enabler use is voluntary and the least restrictive option possible.  There were four residents at with restraints at the time of the audit (all PG). The implemented policy around the management of disturbed behaviours reduces the need for restraint. |
| 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 | Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that includes responsibilities for key staff at an organisational level and a service level. The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. Individual approved restraint is reviewed at least three-monthly at Hawthorne and as part of the care plan review and multidisciplinary review that involves family/whānau. This had occurred for each of the three files reviewed for residents using restraint. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family/whānau. All assessments are reviewed by the clinical nurse manager and the restraint coordinator as sighted in the three files sampled for residents who use restraints.  Assessments are completed as required for individual residents. The three files sampled identified that a restraint assessment, discussion and alternatives form and restraint discussion and consent form were completed for the three residents requiring restraint and an enabler assessment. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The restraint team includes the restraint coordinator who is a registered nurse and all other registered nurses.  Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, duration and its outcome that aligns with a) - g) in this criterion. Restraint monitoring forms include type of restraint used, risks associated with type of restraint, times restraint on/off, toileting, wheelchair lap belt use and repositioning of a resident when in bed. Forms include assessment, monitoring, risks, consent and alternatives to restraint.  Three restraint files reviewed had a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. Monitoring forms were completed. A monthly evaluation of restraint was completed. Care plans documented management of the risks associated with restraint use and the required frequency of monitoring as determined by the level of risk.  The service has a restraint register and enablers register that records sufficient information to provide an auditable record of restraint use. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The files reviewed of residents requiring restraint have been evaluated at least three-monthly. Family/whānau participate in evaluations and at the residents' multidisciplinary review. Use of restraint is discussed at monthly registered staff meetings. The restraint evaluation includes the areas identified in 2.2.4.1 a) – k).  A restraint evaluation is completed of the restraint care plan three-monthly. Evaluation timeframes are determined by risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Approved restraint for each individual is reviewed at least three-monthly by the restraint approval group (registered nurses) and as part of the annual multidisciplinary review with family/whānau involvement.  Restraint usage across the facility is monitored monthly and is discussed at monthly RN meetings. Restraint usage is also benchmarked across the organisation and is reviewed at the organisational level. |

# 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 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | The service collects data around incidents and accidents, infections, resident feedback and complaints. The data is provided to Radius head office and benchmarked. However, there was no evidence of this data having been analysed for trends. There are regular quality, registered staff and all staff meetings but meeting minutes do not include discussion of quality data. Residents interviewed described being well informed with resident/relative meetings held bi-monthly in January, March and May. | (i) There was no documented evidence of accidents and incidents or infections having been analysed for trends. (ii) Meeting minutes (quality, registered staff and staff) did not include discussion around trends (including but not limited to pressure injuries, incidents and infections), corrective action plans or complaints. | (i & ii) Ensure that quality data is analysed for trends and that staff are informed of the outcomes of quality activities including trend analysis.  90 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 | In 2016 and early 2017 not all required training topics had been addressed and staff attendance at training had been poor. Radius identified this issue and a corrective action plan was developed and implemented. This included an experienced Radius roving manager being seconded to Hawthorne to primarily focus on staff training. Training sessions have been provided with each session being provided more than once on different days and at different times of day to ensure high attendance. All required training except wound management and cultural safety have now been provided. The roving manager is a qualified Careerforce assessor and all staff working in the psychogeriatric units are now enrolled in or have completed the required dementia standards but not all contractual requirements had been met at the time of the audit. As these issues had been identified and are being actively addressed the risk has been assessed as low. | (i) There has been no staff training around wound management or cultural safety in the past two years. (ii) Staff attendance at some required trainings was low. (iii) Eleven healthcare assistants who have worked in the psychogeriatric units for longer than one year have not yet completed the required dementia standards. | (i) Ensure that all required trainings are provided. (ii) Continue to ensure that sufficient staff attend education sessions. (iii) Ensure that all staff who have worked in the psychogeriatric units for longer than one year have completed the required dementia standards.  180 days |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Low | The service has a registered nurse on duty 24 hours per day in each of the two psychogeriatric units and a registered nurse on duty in the hospital units (Sumner and Wanaka/Tekapo) on afternoon and night shift. They are supported by sufficient numbers of healthcare assistants. The service has made two notifications about a shift where they have had one registered nurse down. An enrolled nurse works full time morning shift in the hospital units. When this person is rostered during the week the clinical nurse manager provides oversight in these wings. The initial sample of four weeks roster had the enrolled nurse on duty for one weekend. The sample was expanded to include an additional five weeks and there was another weekend where the enrolled nurse was rostered on duty. As there are two registered nurses in the facility at all times that the enrolled nurse can consult with, the risk is assessed as low. | Over nine weeks of the roster sampled there were two weekends where there was an enrolled nurse but no registered nurse on duty in the hospital on morning shift. | Ensure there is a registered nurse on duty in the hospital wings at all times.  30 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | The registered nurse competency register documents that all RNs had their medication competency assessed in June 2017, however not all staff had a current competency prior to this. | Two of three RN files sampled did not have a medication competency completed when they commenced employment. | Ensure all staff who administer medications have a documented competency on file.  90 days |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | All medication files sampled contained accurate and legible prescribing information, demographic details and current photographs. Not all files had allergies documented. | Three of sixteen medication files sampled did not have allergies, or allergy status documented. | Ensure all medication charts have the allergy status documented.  30 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | All resident files sampled had current interRAI and long-term care plans documented and reviewed. Not all documentation was completed within expected timeframes. InterRAI contractual requirements had not previously been met as the service had no interRAI trained RN’s. This issue has now been addressed and all residents now have current interRAI assessments | Four of eight files sampled (two hospital and two psychogeriatric) did not have a long-term care plan completed within three weeks of admission.  Two of four files sampled under the ARHSS contract did not have contractual timeframes around interRAI met. One hospital file sampled had a period of 11 months between evaluations. | Ensure all assessment, care plan and evaluation requirements are completed within contractual timeframes.  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 | All care plans requiring evaluation had current documentation, however the documentation did not always include progress against the goals. | Five of eight care plans sampled (two psychogeriatric including one on a long-term support chronic health condition contract and three hospital including one on an ACC contract) did not document progress towards goals. | Ensure evaluations document progress toward desired outcomes.  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.