

Radius Residential Care Limited - Radius Thornleigh Park

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Radius Residential Care Limited
Premises audited:	Radius Thornleigh Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 September 2018 End date: 19 September 2018
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

Indicator	Description	Definition
Yellow	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
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Thornleigh Park is part of the Radius Residential Care Group. The service provides hospital (medical and geriatric) and rest home level care for up to 63 residents. At the time of the audit there were 52 residents in total.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service is managed by a facility manager who has been in the role for three years and has over 20 years of management experience. The facility manager is supported by an experienced clinical nurse manager who has been in the position for one year. Residents and family members interviewed spoke positively of the services provided at Thornleigh Park.

This certification audit identified two areas for improvement; one related to wound care and enabler documentation and one high risk finding related to medication documentation.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review process. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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A facility manager and clinical nurse manager are responsible for the day-to-day operations. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities, including Radius key performance indicators, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings are held bi-monthly and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An education and training programme has been implemented with a current plan in place. An orientation programme is in place for new staff. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate coverage

for the effective delivery of care. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP. There is an activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals. Residents and relatives interviewed were complimentary about the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and there are sufficient communal toilets. There is space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas. The outdoor areas are safe and easily accessible and there is seating and shade available. Cleaning and laundry staff are providing appropriate services. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. At the time of the audit there were no residents using restraints and four residents using enablers. Staff receive regular education and training on restraint minimisation and managing challenging behaviours.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Radius facilities. Staff receive ongoing training in infection control.

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	43	0	1	0	1	0
Criteria	0	91	0	1	0	1	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with seven care staff, including six healthcare assistants (HCA) and one activities coordinator confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Six residents (four rest home and two hospital) and three relatives (two rest home and one hospital) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice. Staff receive training on the Code, last occurring in August 2018.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their EPOA. Advanced directives are signed for separately. There was evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Eight of eight resident files sampled (five from the rest home and three from the hospital) had a signed admission agreement and consents.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, (eg, attending cafes, and restaurants). Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility. There is a complaint's register that includes relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings. There have been six complaints made in 2018 year to date. The complaints reviewed included follow-up meetings and letters and resolutions. Documentation sighted aligned with the required timeframes as determined by the Health and Disability Commissioner. One of the complaints received in April 2018 was reopened and made through the district health board (DHB) in August 2018, the complaint was investigated, followed up and closed off by the DHB.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code of Rights. Monthly resident/relative meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	<p>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. The 2018 satisfaction survey identified 85% of residents were happy with privacy. Contact details of spiritual/religious advisors are available. Staff education and training</p>

<p>Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>on abuse and neglect has been provided, last occurring in August 2018.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Thornleigh Park has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of audit, there was one resident who identified as Māori. The resident file was reviewed and included a Māori health plan. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Māori consultation is available through the local Iwi and a local Māori Chaplin who visits on a regular basis.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values. The 2018 satisfaction survey identified 100% outcome for cultural/spiritual needs being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. The staff/quality meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the facility manager, clinical nurse manager and RNs confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The Radius quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. Policies and procedures have been reviewed and updated at organisational level and are available to staff. Staff meetings and residents' meetings have been conducted monthly. Residents and relatives interviewed spoke positively about the care and support provided. Staff had a sound understanding of principles of aged care and stated that they feel</p>

		supported by the facility manager, clinical nurse manager and nursing staff. There are implemented competencies for HCAs and RN. 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	Residents and family members interviewed confirmed they were welcomed on entry and were given time and explanation about services and procedures. Family members also stated they are informed of changes in the health status of residents and fifteen incidents/accidents sampled confirmed this. Resident/relative meetings are held bi-monthly. The facility manager and clinical nurse manager have an open-door policy. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made 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	<p>Thornleigh Park is part of the Radius Residential Care Group. The service cares for up to 63 residents requiring hospital (geriatric and medical services) and rest home level care. There are six dual-purpose beds. On the day of the audit, there were 52 residents in total, 34 residents receiving rest home level care, including one resident on a 'younger persons with disability' (YPD) contract, one long-term support chronic health condition (LTS-CHC) contract and one on an ACC funded contract. There were 18 residents receiving hospital level care, including two YPD residents.</p> <p>Thornleigh Park continues to work towards its documented 2018/2019 business plan that is linked to the Radius Residential Care group strategies and business plan targets. The mission statement is included in information given to new residents. An organisational chart is in place. Annual goals have been identified and strategies are documented to meet their three goals around staffing, orientation processes and increasing occupancy.</p> <p>Quarterly reviews are undertaken to report on achievements towards meeting business goals and action plans from previous external audits. The facility manager reports monthly to the regional manager on a range of operational matters in relation to Thornleigh Park, including strategic and operational issues, incidents and accidents, complaints, health and safety.</p> <p>The facility manager is a registered nurse (RN) who is experienced in aged care and has been in the role for three years and has over 20 years of management experience. An experienced clinical nurse manager who has been in the position for one year supports her. A regional manager supports the facility manager in the management role and was present during the audit.</p> <p>The facility manager has completed in excess of eight hours of professional development in the past 12 months.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the facility manager, the clinical nurse manager is in charge, with support from the regional manager and registered nurses.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is an organisational business plan that includes quality goals and risk management plans for Thornleigh Park. The facility manager advised that she is responsible for providing oversight of the quality programme. Thornleigh Park is implementing the Radius quality and risk programme. Monthly staff and quality meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include detailed trend analysis and graphs. Other meetings include; monthly RN and infection control meetings, quarterly health and safety meetings, monthly resident meetings and weekly head of department meetings. Meeting minutes are comprehensive and are reflective of the quality process and plan. Issues are identified, and plans are carried through from meeting to meeting until resolution. Resident/relative meetings are monthly.</p> <p>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 managers' group, with input from facility staff, reviews the service's policies at 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. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions are evaluated and signed off when completed. Restraint and enabler use is reviewed at the monthly staff/quality meeting.</p> <p>Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The overall service result for the resident/relative satisfaction survey completed in February 2018 was at 96%. A corrective action plan was developed and completed in April 2018 around food service and activities. Health and safety policies are implemented and monitored by the health and safety</p>

		<p>committee. The health and safety representative (maintenance person) interviewed confirmed his understanding of health and safety processes. He has completed external health and safety stage three training. Risk management, hazard control and emergency policies and procedures are in place. Hazard identification forms and an up-to-date hazard register (last reviewed 12 September 2018) are in place. Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Incidents are included in the Radius key performance indicators (KPI). There is a discussion of incidents/accidents at the monthly staff/quality meetings including actions to minimise recurrence. A review of fifteen incident/accident forms from August 2018 identified that forms are fully completed and include follow-up by a RN. Neurological observations were completed for twelve reviewed unwitnessed falls or suspected injury to the head.</p> <p>Discussions with the facility manager and regional manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been two section 31 notifications made since the last audit. One was for an unstageable pressure injury in August 2018 and one was for a town water supply cut off in February 2018.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Seven staff files reviewed (one clinical nurse manager, two RNs, two HCAs, one activities coordinator and one maintenance person) include a 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. Registered nurses are supported to maintain their professional competency. The orientation programme provides new staff with relevant information for safe work practice.</p> <p>Staff are required to complete written core competencies during their induction. These competencies are repeated annually. There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. One of seven RNs (the clinical nurse manager) has completed their interRAI training. Advised interRAI trained RNs is low due to RNs leaving the service to work at the DHB. The service is in the process of booking more RNs into the interRAI training. Registered nurses are supported to maintain their professional competency.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is policy in place to determine staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. There is a full-time facility manager and clinical nurse manager who work from Monday to Friday and are available on call 24/7. There is a minimum of one RN on-site at any time. At the time of the audit there were 52 residents in total, 34 rest home residents and 18 hospital residents. There is one RN on duty in the morning shift, afternoon shift and the night shift.</p> <p>The RNs are supported by six HCAs on the morning shift (all long shift) and five HCAs on the afternoon shift (four long and one short shift) and two HCAs on the night shift. Additional staff are often rostered for higher acuity residents and/or days when the workload is higher, and this was seen on the roster. Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the clinical nurse manager and facility manager who respond quickly to after-hour calls.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files sampled 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. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager and the clinical nurse manager screen all potential residents prior to entry and record all admission enquires. The admission agreement form in use aligns with the requirements of the ARRC 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.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</p>

services.		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA High	<p>Radius Thornleigh uses a paper-based medication system. 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 administer medicines. All staff that administer medication are competent and have received medication management training.</p> <p>The facility uses a four-weekly blister pack medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this and any discrepancies are fed back to the pharmacy. All residents have individual medication orders with photo identification and allergy status identified. There were no residents self-administering medicines. Medicines administered are signed on the 24-hour pharmacy generated signing sheets. It was noted that all six RN's (new CAP RN's) currently employed are very new to the facility and range in experience from 2 days to six months.</p> <p>Shortfalls were identified around medication management.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a fully functional kitchen and all food is cooked on-site. There is a food services manual in place to guide staff. A food control plan is registered and due for renewal in November 2018. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. Residents interviewed spoke positively of the meal service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the</p>	FA	<p>There is an admission information policy. The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The potential resident would be referred back to the referring service.</p>

organisation, where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments were completed and were reviewed at least six monthly or when there was a change to a resident's health condition in files sampled. The service has transitioned from a paper-based resident file system to electronic resident records. Previous paper-based records including interRAI are scanned into the electronic records. A number of risk assessment tools are completed as part of the electronic records. The outcomes of the assessment tools and interRAI are linked to the long-term care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Electronic care plans for long-term residents describe the individual support and interventions required to meet the resident goals. Initial risk plans are developed on admission (as applicable) to alert staff to any resident risks such as pressure injury of falls. The long-term care plans reflect the outcomes of risk assessment tools and the interRAI assessment, however not all care plans include all required interventions (link 1.3.6.1). Care plans demonstrate service integration and include input from allied health practitioners. Short-term care plans were in use for changes in health status. These are evaluated regularly and either resolved or if an ongoing problem, added to the long-term care plan. Residents/relatives interviewed confirmed they participate in the care planning process. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. There was evidence of service integration with documented input from a range of specialist care professionals.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>Registered nurses (RNs), the clinical nurse manager and healthcare assistants follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the 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.</p> <p>Wound assessment, monitoring and wound management plans are in place for eight residents with seven wounds and three pressure injuries. Wound documentation reviewed included assessments, monitoring and management plans. Wound documentation reviewed did not reflect that all wounds had been reviewed in the timeframe stated. The RNs have access to specialist nursing wound care management advice through the DHB. Care plan interventions including nutritional intake, regular checks and repositioning charts demonstrate interventions to meet residents' needs. All two hourly turning charts reviewed consistently documented two hourly turns. The files for the four residents</p>

		using enablers were reviewed. Three of the four resident care plans did not include interventions or risks associated with enablers.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities staff provide an activities programme Monday to Friday each week. On admission, activities staff get to know the resident and contribute to the care planning by gathering information on the resident's life history and activities profile. This information is entered into the electronic resident management system and is reviewed six monthly. Activities staff maintain a record of attendance and document levels of participation in the electronic progress notes. The programme is planned monthly and residents receive a personal copy of planned activities. Weekly activities are displayed on noticeboards around the facility. Group activities include garden walks, exercises, puzzles, arts and crafts, reading and entertainment. One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. Themes and events are celebrated.</p> <p>Radius Thornleigh promotes community involvement and has established relationships with a local kindergarten, church groups, local Alzheimer's group, and the SPCA. The service has established a 'random acts of kindness' programme which involves residents contributing to a variety of community acts including baking contributions and gifting at Christmas and Easter. This initiative has had a positive impact on the residents' well-being and interest in the local community. Outings occur weekly and include community dinners, picnics and library trips. On interview, the team advised the programme may vary according to resident requests or weather conditions. Specific activities for younger residents are provided based on their individual preferences. There are monthly resident meetings, where residents have the opportunity to provide feedback on all aspects of the facility. Family communication events are held. Residents interviewed stated they feel the activities are very good, and they are kept as busy as they want to be.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>In files sampled all initial care plans were evaluated by the registered nurses within three weeks of admission. The long-term care plans reviewed were evaluated at least six monthly or earlier if there was a change in health status. There is at least a three-monthly review by the GP. All changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed, and the resident was reassessed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff in the laundry and sluice rooms. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled correctly and stored safely throughout the facility. Safety datasheets are available. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The single storey building accommodates five wings with a number of alcoves and lounge areas in each unit. The building has a current warrant of fitness that expires 5 May 2019. A full-time maintenance person is responsible for the reactive and planned maintenance programme. All requests are recorded in a register held at the main reception (sighted), which has been signed off as requests have been addressed. There is a 12-monthly planned maintenance schedule in place that includes the calibration of medical equipment, electrical testing (bi-annually) of electric beds and hoists and electrical testing. There are essential contractors available 24/7. The maintenance person is available on-call for urgent facility matters.</p> <p>Hot water temperatures in resident areas are monitored monthly and stable below 45 degrees Celsius. The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate storage and space, including a mobility scooter parking/charging bay. The external area is well maintained. Residents have access to safely designed external areas that have seating and shade. Staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans including; sensor mats, standing and lifting hoists, hospital lounge chairs, mobility aids, transferring equipment and pressure relieving mattresses and cushion.</p> <p>Since the previous audit the service has upgraded the look of the facility internally. They have</p>

		purchased new electric beds, bedroom furniture, lounge chair and fall out chairs. They have refurbished the kitchen to be more user friendly and replaced benches and refurbished Harrison dining room.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Several bedrooms have their own toilets and one has a full ensuite. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	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 care residents in the dual-purpose and hospital level rooms. Residents are encouraged to personalise their bedrooms.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	The communal areas include the main lounge and several smaller lounges and separate dining areas in each of the wings. The communal areas are easily and safely accessible for residents.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting</p>	FA	The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. Residents interviewed stated they are happy with the cleanliness of their bedrooms and communal areas. Other feedback is received through resident meetings, annual surveys (resident and relative) and the results of internal audits. All laundry is done in the on-site commercial laundry by dedicated laundry staff. The laundry is secured with a keypad lock system.

<p>in which the service is being provided.</p>		
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an emergency health management plan in place to guide staff in managing emergencies and disasters. The emergency plan was put into practice when the town water supply was cut off in February 2018. A corrective action plan was developed and implemented for any improvements required from the water supply cut off. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. There are first aid kits available in the van, kitchen and nurses station. Thornleigh Park has an approved fire evacuation plan in place. Fire evacuation drills occur six monthly with the last evacuation drill occurring on 28 August 2018. Smoke alarms, sprinkler system and exit signs are in place.</p> <p>The service has alternative cooking facilities (BBQ and gas hobs in the kitchen). The service has a backup system for emergency lighting and battery backup for up to four hours. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are available. There are civil defence kits in the facility that are checked four monthly. There is sufficient water (ceiling water tanks and bottled water) stored. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitors' book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight. Residents and relatives confirmed satisfaction with the temperature of the facility.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and</p>	<p>FA</p>	<p>Radius Thornleigh has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPIs. The clinical manager is the designated infection control nurse with support from the registered nurses 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 infection control programme is reviewed annually by Radius head office.</p>

scope of the service.		
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The clinical manager at Thornleigh is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the quality management team and care staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Radius and the policies have been developed at head office. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control nurse is responsible for coordinating/providing education and training to all staff. The infection control nurse has completed infection control training. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management training is provided both at orientation and as part of the annual training schedule. Infection control is an agenda item on the full facility and clinical meeting agenda. Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs. 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.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection control coordinator completes a monthly report. Monthly data is reported to the quality and staff meetings. Staff are informed of infection control through the variety of facility meetings. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there were no residents using restraints and four residents using enablers (three D bars and one Monkey bar). Three of four resident care plans reviewed did not include interventions or risks associated with enablers (link 1.3.6.1). Staff training has been provided around restraint minimisation in April 2018 and managing challenging behaviours in August 2018.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA High	<p>The registered nurses are responsible for the safe administration of medication with healthcare assistants competent to act as second checkers when required. One medication round observed followed correct practice, however a review of medication charts evidences that prescribing practices and signing for administration of medications are areas for improvement. The facility owned syringe driver is checked annually, however this had not occurred as planned.</p>	<p>(i) Five of sixteen administration signing sheets evidenced unexplained gaps.</p> <p>(ii) Six of sixteen ‘as required’ medications administered, did not document the time of administration.</p> <p>(iii) The controlled drug register did not record times of administration for two residents.</p> <p>(iv) The controlled drug register did not record the balances columns correctly for two residents.</p> <p>(v) The controlled drug signing sheets did not evidence two</p>	<p>(i) –(ii) Ensure that medications administered are signed for as given and ‘as required’ medications include the time of administration.</p> <p>(iii)- (iv) Ensure the controlled drug register is completed including time of administration and with balances correctly recorded.</p> <p>(v) Ensure two signatures are</p>

			<p>signatures for two files reviewed.</p> <p>(vi) Three of sixteen medication charts reviewed had short-term medications with no stop dates.</p> <p>(vii) The calibration of the syringe driver due in April 2018 had not been completed.</p>	<p>recorded on the administration signing sheet for all controlled drugs as per policy.</p> <p>(vi) Ensure that short-term medications have a stop date documented.</p> <p>(vii) Ensure the syringe is calibrated annually.</p> <p>7 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Wound documentation available includes a wound assessment and management plan and a wound review chart, which documents the timeframe for the review of the wound and the current state of the wound. Not all wounds had been reviewed within the stated timeframe. The files for the four residents using enablers were reviewed, however three of the four resident care plans did not include interventions or risks associated with enablers.</p>	<p>(i) Three of the eight current wounds (two chronic ulcers and one skin tear) have not been reviewed within the stated timeframe. (ii) Four residents with enablers were reviewed. Three of the four electronic care plans reviewed did not include interventions or risks associated with enablers.</p>	<p>(i) Ensure documentation reflects that wounds are reviewed as per the documented management plan. (ii) Ensure that all resident care plans include interventions or risks associated with enablers.</p> <p>90 days</p>

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

No data to display

End of the report.