

Radius Residential Care Limited - Radius Arran Court Rest Home & Hospital

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 Arran Court Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 5 December 2018 End date: 6 December 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:	91

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

Arran Court is owned and operated by Radius Residential Care Limited and is certified to provide care for up to 102 residents requiring rest home and hospital (medical and geriatric) and residential disability- physical level care. On the day of the audit there were 91 residents.

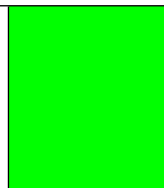
The service is managed by an experienced facility manager. She is supported by a Radius regional manager and a clinical manager. Residents and relatives spoke positively about the service provided.

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

This audit has identified one area for improvement around linking the residents' interRAI assessments to their care interventions.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.



Standards applicable to this service fully attained.

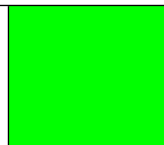
Policies and procedures adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents, and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Standards applicable to this service fully attained.

A facility manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded in practice. Results are shared with staff. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments. Registered nursing cover is provided 24 hours a day, 7 days a week.

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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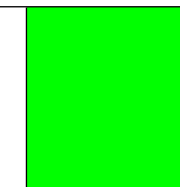
There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner/nurse practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The activities coordinators implement the 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.

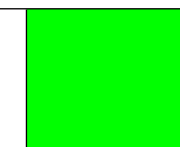
All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents were satisfied with the meals and commented positively on the baking provided.

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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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All rooms have toilets and hand basins and there is one ensuite. There are sufficient communal showers/toilets. External areas are safe and well maintained with shade and seating available. Emergency management procedures are in place. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are monitored through the internal auditing system.

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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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures being implemented for the safe assessment and review of restraint and enabler use. A register is maintained. During the audit seven residents were using an enabler and six residents were using a restraint.

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 clinical manager is the infection control coordinator who is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

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	49	0	0	1	0	0
Criteria	0	100	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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>Radius Arran Court Rest Home and Hospital policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission which includes information about the Code. Staff receive training about resident rights at orientation and as part of the in-service programme. Interviews with 15 staff (six healthcare assistants across the am and pm shifts, three registered nurses (RNs) and two activities staff, one cook, one maintenance staff, one office administrator, one cleaner) confirmed their understanding of the Code and its application to their job role and responsibilities.</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>The service has in place a policy for informed consent. Completed resuscitation status and general consent forms were evident on all files (electronic) reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney forms are also filed in the residents' files.</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>	<p>FA</p>	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on residents' family/whānau and chosen social networks.</p> <p>The Nationwide Health and Disability Advocacy service is an invited speaker at resident/family meetings and at staff training on the Code and the role of advocacy services.</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>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit.</p> <p>Two residents (YPD) have their own pets. The service is responsive to YPD residents accessing the community, resources, facilities and mainstream supports in the community with specific examples provided during the audit. They are taken out for shopping visits and one resident regularly attends the local community stroke club.</p> <p>The activities programme includes opportunities to attend events both within and outside of the facility. 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>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission.</p> <p>Interviews with residents and relatives confirmed their understanding of the complaints process with examples provided. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register that includes complaints received, dates and actions taken. The facility manager signs off each complaint when it is closed. Twenty-five complaints have been lodged for 2018 (year to date) and were reviewed during the audit. Complaints reviewed were being managed in a timely manner, meeting requirements determined by HDC. Three of the twenty-five complaints that have been lodged in the past month are open. The remaining 22 complaints have been signed off by the facility manager. One complaint lodged with HDC in 2017 also remains open, and remains under investigation by HDC.</p>

		The complaints process is linked to the quality and risk management system with trends identified and corrective actions implemented. There is evidence of lodged complaints being discussed in the staff meetings.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Nine residents (four rest home, five hospital including two younger persons with a disability [YPD]) and nine relatives (five hospital including one YPD, four rest home) interviewed, confirmed that information had been provided to them around the Code. Posters of the Code and advocacy information are displayed in English and in Māori. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Young people with disabilities are able to maintain their personal gender, cultural, religious and spiritual identity, evidenced in the file reviewed of a resident who was under the YPD contract and in interviews with two YPD residents. Care staff interviewed could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with healthcare assistants described how choice is incorporated into resident cares.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The Māori health plan policy for the organisation provides recognition of Māori values and beliefs. The facility maintains links with the local Māori community. Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged. Links are established with disability and other community representative groups as requested

		<p>by the resident/family. Māori cultural needs are addressed in a specific Māori health plan. Rooms are blessed following the death of a resident.</p> <p>During the audit, there was one Māori resident (YPD/hospital) living at the facility who identified with his culture. A specific and comprehensive Māori health plan has been developed for this resident. The family member and resident both commented that they had input into the plan.</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>	FA	<p>Radius Arran Court is home to a significant number of residents from varying cultures and backgrounds. Following the resident's admission to the facility, an initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. All ten resident files reviewed evidenced that individual beliefs or values are discussed and incorporated into the care plan.</p> <p>Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed, confirmed that staff take into account their values and beliefs. Activities and entertainment includes celebrating various cultural days/events.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility has implemented a code of conduct. The facility manager and clinical manager supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation.</p> <p>Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. A code of conduct agreement is signed by staff during their orientation. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Interviews with the managers and care staff confirmed their awareness of professional boundaries. Management provided guidelines and examples of mentoring for specific situations.</p> <p>All residents interviewed reported that the staff respect them.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the health and disability services standards. Staffing policies cover pre-employment processes and the new employee's requirement to attend orientation</p>

		<p>and ongoing in-service training. The managers are responsible for implementation of the internal audit programme. Monthly staff meetings and regular residents' meetings are conducted. There is a regular in-service education and training programme for staff. Staff interviewed stated that they feel supported by the facility manager and clinical manager.</p> <p>Evidence-based practice is evident, promoting and encouraging good practice. A house general practitioner (GP) visits the facility twice per week. The service receives support from the local district health board (DHB). Physiotherapy services are available six hours per week. A podiatrist visits every six to eight weeks. The service has links with the local community and encourages residents to remain independent.</p> <p>Residents and relatives interviewed spoke positively about the care and support provided.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the electronic system. All 15 accidents/incidents reviewed met this requirement. Family members interviewed commented that they are notified following a change of health status of their family member.</p> <p>Family/resident meetings provide a venue where issues can be addressed.</p> <p>There is an interpreter policy in place and contact details of interpreters were available. At the time of the audit, there were 14 resident who were limited in their ability to understand English. Staff and family are used as interpreters in the first instance. The regional manager reported that interpreter services through the DHB have been used in the past, and are available if needed. Communication information sheets are laminated and made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Radius Arran Court Rest Home and Hospital has a total of 102 beds and is certified for rest home, hospital (including medical) and residential disability- physical. All beds are dual-purpose. At the time of the audit there were 91 beds occupied. Thirty-eight residents were rest home level, which included two residents on a long-term support - chronic</p>

		<p>health condition contract (LTS-CHC) and one resident on an interim funding programme (IFP) contract. Forty-six residents were hospital level, including two residents on a LTS-CHC contract and one resident on respite. Seven of the residents were on the younger persons with disability (YPD) contract (one rest home level and six hospital level). All beds are dual-purpose.</p> <p>The Radius Care strategies 2018-2021 describe the vision, values and objectives of Radius aged care facilities. The 2018-2019 business plan is specific to Radius Arran Court and describes specific and measurable goals that are regularly reviewed (June 2018, Sept 2018) and updated.</p> <p>The facility manager was a registered nurse (RN) but no longer holds a current practising certificate. She was appointed to this role in August 2018. In addition to her nursing background, she has previous senior management experience including operational and service delivery management in not-for-profit sectors. She is supported by a regional manager (who was present during the audit) and a clinical manager. The clinical manager role was filled by an experienced RN on 4 October 2018. He has worked in the aged care sector since 2010 and has clinical experience in rest home, hospital and dementia levels of care.</p> <p>The facility manager and clinical manager have maintained at least eight hours of professional development activities related to managing an aged care facility.</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>	FA	<p>The clinical manager/RN covers during the temporary absence of the facility manager. For extended absences, Radius has interim (roving) facility managers who cover facility manager absences. The regional manager is available on a consultative basis.</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>	FA	<p>An established quality and risk management system is embedded into practice. Quality and risk performance are reported in staff meetings and to the regional manager. Discussions with the managers and staff reflected the staff's involvement in quality and risk management processes. Residents including those under the YPD contract, also have input into quality improvements and regularly attend the monthly resident meetings.</p> <p>Annual resident and relative surveys were last completed in July 2018</p>

		<p>with 30 responses. Results were collated and discussed with staff. No trends were identified. Plans are in place to complete another satisfaction survey in early 2019, to evaluate the effectiveness of the new facility manager and clinical manager.</p> <p>The service has policies and procedures and associated implementation systems, adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level every two years. Clinical guidelines are in place to assist care staff.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are guidelines and templates for reporting. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff in meetings and on staff noticeboards.</p> <p>Corrective action plans are implemented when opportunities for improvements are identified (eg, internal audit results are lower than 95%, and partially attained criteria from previous audits). Corrective actions are evaluated and signed off when completed. Quality improvement plans (QIPs) are developed where opportunities for improvements are identified. QIPs for 2018 were documented around staff education, clinical review meetings, and business strategies.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. The health and safety officer (administration officer) was interviewed about the health and safety programme. She has completed health and safety training (stages one, two and three). Risk management, hazard control and emergency policies and procedures are in place. The hazard register was last reviewed on 28 November 2018. There are procedures to guide staff in managing clinical and non-clinical emergencies.</p> <p>Falls prevention strategies are in place including assessing those residents who are at risk of falling. Sensor mats, perimeter mattresses and intentional-rounding practices are implemented to reduce falls.</p>
Standard 1.2.4: Adverse Event Reporting	FA	There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting,

<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>		<p>monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed electronically for each incident/accident with action(s) noted and any follow-up action(s) required.</p> <p>A review of 15 accident/incident forms identified that forms are fully completed and include follow-up by a registered nurse and sign-off by the clinical manager. Accident/incident forms are completed when a pressure injury is identified. Neurological observations are completed for any suspected injury to the head.</p> <p>The facility manager and regional manager were able to identify situations that would be reported to statutory authorities including (but not limited to): infectious diseases, serious accidents and unexpected death. There was evidence of three Section 31 reports completed in 2018 (resident aggression, stage three pressure injury, allegation of theft).</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>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Nine staff files reviewed (one clinical manager, two RNs, five healthcare assistants, one housekeeper) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice and includes a system for determining staff competency across a range of topics (eg, falls prevention, communication, restraint, basic cares/observations, aging process, infection control, informed consent). There is an implemented annual education and training plan that meets contractual requirements. All staff participate in continuing education relevant to physical disability and young people with physical disabilities. There is an attendance register for each training session and an individual staff member record of training. Performance appraisals were up to date in the staff files reviewed of staff who had been employed for one year or longer.</p> <p>Registered nurses are supported to maintain their professional competency. Four registered nurses have completed their interRAI</p>

		training and one is currently in training. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale.</p> <p>The rest home unit (Piha wing) has 18 rest home and 10 hospital level residents. It is staffed with one RN and three healthcare assistants (HCAs) (two long shift, one short shift) on the AM and PM shifts.</p> <p>Hospital A (Bethells wing) has 8 rest home and 24 hospital level residents. It is staffed with one RN on the AM and PM shifts and six HCAs (three long shift and three short shift) on the AM shift and four HCAs (two long and two short) on the PM shift.</p> <p>Hospital B (13 rest home and 18 hospital) is staffed the same as hospital A.</p> <p>The night shift is staffed with two RNs and four HCAs that cover the entire facility.</p> <p>The facility manager reported that staff turnover has been high, especially for registered nurses, with four RNs exiting the facility in September 2018. Two RN positions remain open. Absenteeism has also been reported as high, with performance management processes in place. The facility manager reported that she is receiving support from head office. Agency staff are used to fill absences, although at times when short notice is given, absences are difficult to fill.</p> <p>Staff were observed attending to call bells in a timely manner. Staff interviewed stated that overall the staffing levels are satisfactory but that it was difficult to manage when staff were absent, and their positions were unable to be filled due to short notice.</p> <p>Residents and family interviewed reported there are sufficient staff numbers.</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>	FA	<p>The residents' files were appropriate to the service type. Data is entered electronically using eCase. Cloud-based back-up storage is being implemented. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's</p>

		individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Entries are dated with electronic signatures by the relevant HCA or nurse. A locked room stores archived (hard copy) residents' files.
<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>	FA	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed, met the requirements of the ARCC. Exclusions from the service are included in the admission agreement. Ten admission agreements sighted were signed and dated.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. An electronic transfer form is printed off and accompanies residents to receiving facilities. Communication with family is made.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. There were no standing orders in use. There were no vaccines stored on site.</p> <p>The facility uses a paper-based and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and medication competent senior HCAs administer medications. Staff have up-to-date medication competencies and there has been medication education in the last year. Some RNs have syringe driver training completed by hospice staff and more are booked for next year. The medication fridge temperature is checked daily. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on signing sheets. Twenty medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</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>	<p>FA</p>	<p>The service has two cooks; one works Sunday to Thursday and one works Friday to Saturday. There are four kitchenhands; two work mornings and two work evenings. All have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are taken to the dining rooms in hot boxes and served directly from these. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available.</p> <p>On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder.</p> <p>The four-weekly menu cycle is approved by the Radius dietitian. All residents and family members interviewed were satisfied with the meals. The residents commented favourably on the home baking.</p> <p>The food control plan was approved on 16 May 2018.</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 organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Electronic files sampled indicated that appropriate information is gathered during admission in consultation with the resident and their relative (where appropriate). InterRAI assessments had been completed for all long-term residents' files reviewed. Overall, the goals were</p>

		identified through the assessment process and linked to care plan interventions (1.3.5.2). Other assessment tools in use included (but were not limited to) falls risk, pressure injury risk, pain and depression.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented do not always match the information in InterRAI, so detail to support needs and guide care is sometimes incorrect. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, dietitian and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.</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>	FA	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed.</p> <p>Resident falls are reported electronically and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently nine wounds being treated. This includes one stage two pressure injury. The stage two pressure injury and the surgical wound have had input from the GP and wound care nurse specialist. There are photos to show wound progress.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	FA	<p>There are two activities coordinators, one works 42.5 hours a week and one works 30 hours a week. There are currently no set weekend</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>activities, but the facility is about to trial these. On the days of audit residents were observed doing exercises, going for a supervised walk around the block, playing scrabble, listening to newspaper readings and enjoying pet therapy. There was also a residents' meeting.</p> <p>There is a weekly programme in large print on noticeboards and residents also have a copy in their rooms. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There is a fortnightly interdenominational church service and Catholics have communion from the local parish on a Sunday. There are also visits for Hindi and Seventh Day Adventist residents. There are weekly van outings. There are entertainers visiting the facility, but the activities coordinators want to make these more regular. Special events like birthdays, Easter, Fathers' Day, Anzac Day, Chinese New Year and Matariki are celebrated.</p> <p>The facility has two cats and a pet therapy team visits monthly.</p> <p>There is community input from a local intermediate school, kindergartens volunteers, RSA, Kapa Haka groups and the local Women's Centre. Some residents go out to the shops, stroke club and the Tamil community centre.</p> <p>The eight younger people have widely different interests including shopping, craft, chess, pets and play station. The activities coordinators cater for these interests and also ensure that they have more modern DVDs and music available. The YPD residents also join any other activities that they wish to participate in.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly, at the same time as the review of the long-term care plan. Resident meetings are held monthly.</p>
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<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The nine long-term care plans reviewed had been evaluated by the registered nurses six-monthly or when changes to care occurred. Short-term care plans for short-term needs are evaluated and signed off as resolved or are added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three-monthly reviews by the GP for all residents. The family members interviewed confirmed that they are informed of any 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>	<p>FA</p>	<p>Referral to other health and disability services was evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of instances where residents had been referred to the wound care nurse specialist and mental health services for older people. Discussion with a registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. 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>	<p>FA</p>	<p>The building holds a current warrant of fitness, which expires 8 December 2018. Renewal is currently in progress. There is a maintenance person on site for 40-45 hours a week. The maintenance person also mows the lawns, but the gardener is contracted. Contractors are used when required.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. There is a mixture of carpet and vinyl flooring throughout the rest home and</p>

		<p>hospital. The utility areas such as the kitchen and sluice rooms have vinyl flooring. The one ensuite and all showers and toilets have nonslip vinyl flooring. All corridors have safety rails that promote safe mobility. Corridors are narrow, but residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>HCA's interviewed stated they have adequate equipment to safely deliver cares for all levels of care.</p>
<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	<p>All rooms have toilets and hand-basins, but some are shared between two rooms. There is one room with an ensuite. There are sufficient numbers of communal toilets and showers. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. There are signs on all shower/toilet doors.</p>
<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	<p>All resident's rooms are single. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<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	<p>There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. Several lounges open out onto attractive courtyards. There are spacious dining rooms in each area.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is done off site apart from some personal ironing. There is a cleaning manual. Cleaning services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away in the cleaner's cupboard. All chemicals on the cleaner's trolley were labelled. There are three sluice rooms for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms are kept locked when not in use.</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 are emergency and disaster manuals to guide staff in managing emergencies and disasters. The services emergency plan considers the special needs of young people with disabilities in an emergency. There is a minimum of one first aid trained staff member on every shift and during outings. The facility has an approved fire evacuation plan. Fire drills take place every six months. Smoke alarms, sprinkler system and exit signs are in place. Emergency lighting is in place which is regularly tested. A civil defence kit is in place. Supplies of stored water and food are held on-site and are adequate for three days. Electronic call bells are evident in resident's rooms, lounge areas and toilets/bathrooms. The facility is kept locked from dusk to dawn.</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>All bedrooms and communal areas have ample natural light and ventilation. There is gas heating. Staff and residents interviewed stated that this is effective. There is an outdoor gazebo area near the car park where residents may smoke. All other areas are smoke free.</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 scope of the service.</p>	<p>FA</p>	<p>The infection control coordinator (ICC) is the clinical manager. Responsibility for infection control is described in the job description. The ICC oversees infection control for the facility and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed annually by Radius head office.</p> <p>Visitors are asked not to visit if unwell. Hand sanitizers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks.</p>
<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>	<p>FA</p>	<p>The ICC has only been in the role for two months. but has already completed the online Waitemata DHB infection control course. There is access to infection control expertise within the DHB, Radius, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics. The ICC also liaises and meets regularly with the facility and regional manager.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for</p>

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.		the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen and housekeeping incorporate the principles of infection control. The policies have been developed by a Radius infection control specialist.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The ICC is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have recently completed an infection control study day. The ICC has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.
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	There is a policy describing surveillance methodology for monitoring of infections. The ICC collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed at staff, RN and management meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. The facility benchmarks infections with similar Radius facilities.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The clinical manager is the designated restraint coordinator. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. There were seven (hospital level) residents using enablers (one lap belt and six bed rails) and six (hospital level) residents using bedrails as restraint during the audit. One resident file of a resident using an enabler (bedrails) was reviewed. The resident gave written consent for the use of bedrails. The enabler was linked to the resident's care plan and was regularly reviewed. Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.
Standard 2.2.1: Restraint approval and processes	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator and for

<p>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.</p>		<p>staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and/or family/whānau are evident. Two residents' files where restraint (bedrails) were in use were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan, sighted in the two residents' files reviewed. An internal restraint audit monitors staff compliance in following restraint procedures.</p> <p>Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify monitoring was evidenced on the monitoring forms for the residents' files reviewed.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly. Restraint use is also discussed in the monthly restraint meetings, confirmed in the meeting minutes.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The Radius restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>Care plans are documented to support needs and provide guidelines for staff. The staff interviewed found them easy to follow. However, information in four care plans did not match the information in InterRAI, so details to support needs and guidelines for staff were incorrect</p>	<p>In four out of ten files sampled there were discrepancies between the interRAI assessment and the care plan.</p> <p>i) InterRAI states that there is a risk of absconding and the care plan states that there is no risk of absconding.</p> <p>ii) InterRAI states that the resident forgets words and rambles and the care plan states that there is no problem with communication.</p> <p>iii) InterRAI states that the resident needs a one person assist with shower and the care plan states that the resident showers independently.</p>	<p>Ensure there are no discrepancies between interRAI and the care plan so the detail to support needs and guide care is correct.</p> <p>60 days</p>

			iv) InterRAI states that the resident uses the toilet if reminded and the care plan states the resident is incontinent and wears continence products.	
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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.