

Radius Residential Care Limited - Radius Fulton Care Centre

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Radius Residential Care Limited
Premises audited:	Radius Fulton Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 21 August 2019 End date: 22 August 2019
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:	92

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
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Radius Fulton Care Centre provides care for up to 93 residents across three service levels (rest home, hospital (medical and geriatric), and dementia). On the day of audit, there were 92 residents in total.

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

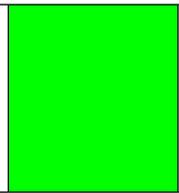
Radius Fulton Care Centre have an established quality and risk management plan embedded into practice. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. The service continues to implement an electronic resident management system.

The facility manager has been in the role for 17 years. The clinical manager registered nurse has been in the role for five years. They are supported by a team of registered nurses and enrolled nurses, healthcare assistants and long-serving staff.

This audit identified the service continues to meet all the standards.

The service is commended for achieving continuous improvement ratings related to falls management, emergency procedures, the activities programme and infection control.

Consumer rights

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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>All standards applicable to this service fully attained with some standards exceeded.</p>
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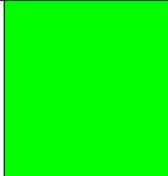
There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. InterRAI assessments are utilised and link to care plans. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses and senior healthcare assistants who are responsible for administration of medicines complete education and medication competencies. The electronic medicine charts were reviewed at least three-monthly by the general practitioner.

An activity programme is implemented for residents in the Glenedin (dementia) wing with 24-hour care plans in place. There is a separate activity plan in place for rest home and hospital level residents, with combined whole facility activities planned each day. Residents and relatives reported satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site by an external company. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Snacks are available in the Glenedin (dementia) wing 24 hours a day.

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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Radius Fulton Care Centre has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Medical equipment and electrical appliances have been calibrated. There is a designated laundry at the site, which includes the safe storage of cleaning and laundry chemicals. There is a documented process for waste management. Residents' rooms are spacious and allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the rest home, hospital and dementia areas that include lounge and dining areas, and smaller seating areas.

The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. All registered nurses have a first aid certificate.

External garden areas are available with suitable pathways, seating and shade provided.

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.

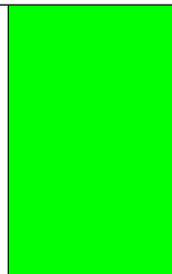


Standards applicable to this service fully attained.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures for the safe assessment and review of restraint and enabler use. A register is maintained. There were nine (hospital level) residents using enablers (bedrails) and two (hospital level) residents using bedrails as restraint during the audit. Assessment and evaluation processes were being implemented.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	49	0	0	0	0	0
Criteria	4	97	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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 Fulton Care 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 nineteen staff: six healthcare assistants (HCAs) (four on the AM and two on the PM shifts), six registered nurses (RNs), two activities staff, two caterers, one maintenance staff, one office manager, one laundry) 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>There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Ten resident files reviewed (four from the hospital including one LTS-CHC and one ACC, three dementia and three rest home level care), included consent for transporting, photographs and provision of care.</p> <p>Training is provided to support staff to provide care and support and enable residents to make choices and be involved in the service. Interviews with healthcare assistants identified that consents are sought in the delivery of personal cares. Written consent includes the signed admission agreements. All ten resident files reviewed included signed consent forms signed by</p>

		<p>the resident/family/whānau/EPOA. The advanced directives/resuscitation policy was implemented in the resident files reviewed. All advance directives are completed by the resident where able, the GP and discussion with relatives is documented. The three dementia files included activated EPOAs.</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 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 residents' files sampled included information on residents' family/whānau and chosen social networks.</p> <p>A health and disability advocate is an invited speaker at resident/family meetings and at staff training on the Code, addressing the role of advocacy services (29 May 2019). Links to HDC advocacy services are provided to complainants.</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. The activities programme includes opportunities to attend events both within and outside of the facility. Resident/family meetings are held each month. Relatives and friends are encouraged to be involved with the service and care. The staff described how they maintain community connections and support residents to maintain community networks and activities.</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. 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 of 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. Two complaints have been lodged in 2019 (year to date) and five complaints were received in 2018.</p> <p>Both complaints received in 2019 were reviewed. One of the complaints was lodged with HDC (29 March 2019) and has been closed by HDC (27 May 2019). The two complaints reviewed were managed in a timely manner, meeting requirements determined by HDC. Evidence of</p>

		<p>family meeting minutes were sighted and both complainants were provided with contact details for advocacy and support. Both complaints were documented as resolved and closed. Regarding the complaint lodged with HDC, corrective actions were documented on a corrective action plan register with evidence to support their implementation. This included staff education/toolbox talks.</p> <p>The complaints process is linked to the quality and risk management system. There is evidence of lodged complaints being discussed in the staff meetings.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>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. Twelve residents (four rest home, eight hospital) and seven relatives (five hospital, two dementia) 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.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>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.</p> <p>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.</p> <p>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. HCAs described how choice is incorporated into resident cares.</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</p>	FA	<p>The Māori health plan policy for the organisation provides recognition of Māori values and beliefs. 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 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 (rest home level) Māori resident living at the facility who was</p>

beliefs.		interviewed during the audit and confirmed that her values and beliefs were being met. A Māori health plan has been developed for this resident although she does not identify with any specific Māori customs.
<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>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 include 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. Staff attend annual training on recognising abuse and neglect.</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>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 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</p>

		<p>practitioner (GP) visits the facility twice per week. The service receives support from the local district health board (DHB). Physiotherapy services are available two days a week and have additional support from a designated physiotherapy assistant. A podiatrist visits every six to eight weeks. The service has links with the local community and encourages residents to remain independent.</p> <p>The service has received four ratings of continuous improvement (CI) where the facility has exceeded what is required in the health and disability support standard. These CIs address strategies to manage residents' falls, emergency evacuation procedures, the activities programme and infection control (link 1.2.3.8, 1.2.4.1, 1.3.7.1, 3.5.7).</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. Staff and family are used as interpreters in the first instance. There were no residents at the care facility at the time of the audit who were unable to speak/understand English.</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>Fulton Care is part of the Radius Residential Care group. The service provides rest home, dementia and hospital (geriatric and medical) levels of care. Over this two-day audit, there were 92 residents living at the facility with 93 beds available. There are 18 dual-purpose beds.</p> <p>Twenty-two residents were rest home level (including one resident funded by ACC). Eighteen residents were in the 19-bed dementia unit including one respite, and fifty-two residents were hospital level (including one resident on a long-term support – chronic health conditions (LTS-CHC) contract, one on a DHB close in age and interest contract, and two residents funded by ACC). All remaining residents were on an age-related residential care (ARRC) contract.</p> <p>The facility manager has been in the role for the past 17 years. The clinical manager (RN) has been in the role for five years, having previously been a clinical manager at another Radius facility. The facility manager reports to a regional manager who 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>The Radius organisation has a philosophy of care, which includes a mission statement. Radius has an overall strategic plan (July 2018 – March 2021) and Fulton Care has a facility business plan (April 2017 to March 2020) that links to the strategic plan. Annual business plan targets (2019/2020) are established and progress to meeting the goals are reviewed quarterly.</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.</p> <p>Annual resident/relative surveys were last completed in May 2019 with 50 responses. Results have been collated and discussed with staff. A corrective action was implemented to address food temperatures, which has been implemented with positive results (evidenced on a food survey completed July 2019).</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. Processes are embedded to collect, analyse and evaluate data, which is utilised for service improvements. There are guidelines and templates for reporting. Key performance indicators (KPIs) are established. Where results exceed what is expected, a corrective action plan is implemented. They are tracked on a corrective action register. Corrective actions are evaluated and signed off when completed. Results are communicated to staff in meetings and on staff noticeboards.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee.</p>

		<p>Four health and safety annual objectives are developed and regularly reviewed. The health and safety officer (office manager) was interviewed. Risk management, hazard control and emergency policies and procedures are being implemented. The site-specific hazard register was last reviewed in June 2019 and the general hazard register developed by head office was last reviewed in May 2019. Staff training begins during their induction to the service and continues through in-services and monthly staff meetings. An induction programme is also being implemented for external contractors (sighted).</p> <p>Falls prevention corrective action plans are implemented which has resulted in a rating of continuous improvement. Numerous strategies to reduce falls reflect evidence of successful results (eg, intentional rounding, vitamin D, exercise programmes to improve the residents' balance, sensor mats). Falls are consistently below the benchmark of 25 falls per month. One family interviewed (hospital) remarked that her mother was a high risk of falling with over 17 falls occurring at another facility over a one-month period of time. Her mum has had no falls at this facility over the past month. She felt that this was the result of encouraging her mum to sit in the lounge vs remain alone in her room for monitoring purposes and the use of a sensor mat.</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. 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 were fully completed and included follow-up by a registered nurse and sign off by the clinical manager. Accident/incident forms were completed when a pressure injury is identified. Neurological observations were completed for any suspected injury to the head or unwitnessed fall.</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 (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</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Nine staff files reviewed (two RNs, six HCAs, one cleaner) included a recruitment process (interview process, reference checking, police check), signed employment contracts and job descriptions and completed orientation programmes. A register of registered nursing staff</p>

<p>with good employment practice and meet the requirements of legislation.</p>		<p>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. In-service education is complimented with impromptu (toolbox) talks and competency assessments. 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. Ten registered nurses are employed, and five registered nurses have completed their interRAI training. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies.</p> <p>There is a total of 42 HCAs with 16 HCAs having either careerforce level 1 or 2 and 26 HCAs have completed either level 3 or 4. There were 11 caregivers who worked in the dementia unit. Ten had completed their required dementia qualification and the one remaining caregiver was in the process of completing.</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>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale across four wings: Both the facility manager and clinical manager are RNs with current practising certificates who work Monday – Friday. Registered nursing staff are rostered across all three shifts with a minimum of one RN (night shift) seven days a week. Use of agency staff has not been required.</p> <p>Glenedin (dementia wing with 18 residents): One RN covers the AM shift (shared with the McKenzie wing). The AM shift is staffed with two long (eight hour) shift HCAs, the PM shift is staffed with one long and two short shift HCAs and the night shift is staffed with one long shift HCA.</p> <p>McKenzie wing (eight hospital and nineteen rest home residents): One RN covers the AM shift (shared with Glenedin wing). The AM shift is staffed with three long shift HCAs, the PM shift is staffed with two long and one short shift HCA and the night shift is staffed with one HCA.</p> <p>Brookside wing (20 hospital and three rest home residents): One RN covers the AM and PM shifts. Two long shift and two short shift HCAs cover the AM shift and the PM shift (note: one HCA is shared with McKenzie on the PM shift). One HCA covers the night shift.</p>

		<p>Lisburn wing (22 hospital and two rest home residents): One RN covers the AM and PM shifts. Three long shift and one short shift HCAs are staffed on the AM shift and two long and two short shift are staffed on the PM shift. One HCA covers the night shift.</p> <p>Activities staffing is seven days a week in the dementia unit and five days a week for rest home and hospital level residents.</p> <p>The laundry, cleaning and kitchen staff are separate to HCA staff.</p> <p>The facility manager reported that staff turnover was higher than expected, especially for registered nurses, but has stabilised. Staff were observed attending to call bells in a timely manner. Staff interviewed stated that overall the staffing levels were satisfactory. Residents and family interviewed reported there were 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 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 were dated with electronic signatures by the relevant HCA or nurse. A locked room stores archived (hard copy) residents' files.</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>	FA	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed aligned with all contractual requirements and kept within the electronic file. Exclusions from the service were included in the admission 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 services.</p>	FA	<p>The RNs interviewed described the nursing requirements as per the policy for discharge and transfers. The yellow transfer envelope is used and the interRAI transfer form. The advanced directive and resuscitation status are included. The resident and relatives are consulted and kept informed.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised robotic packs for regular medications and blister packs for 'as required' (PRN) medications. Medication reconciliation is completed by one RN and one medicine competent HCA on delivery of medication and any errors are fed back to pharmacy. All medications were securely and appropriately stored on the day of audit.</p> <p>All senior staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. RNs have completed syringe driver training.</p> <p>Twenty medication charts were reviewed (six rest home, eight hospital, and six dementia). The service uses an electronic medication management system. All charts had evidence of three-monthly reviews by the GP, and all medications were prescribed appropriately.</p> <p>Staff were observed to be safely administering medications. Registered nurses and healthcare assistants interviewed could describe their role regarding medicine administration. Standing orders were not used. One resident was self-medicating, a competency was in place and reviewed by the GP on a three-monthly basis.</p> <p>The medication fridge temperatures were recorded weekly and these were within acceptable ranges.</p> <p>There was a signed agreement with the pharmacy.</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>All meals at Radius Fulton are prepared and cooked on site by a contracted food service company. The food service company operates the business from the commercial kitchen and provides meal services to several other aged care services and community colleges. A food control plan is in place expiring 31 May 2020. All fridge and freezer were checked and within ranges. End-cooked meal temperature checks were completed and recorded and were within ranges.</p> <p>The food service company has a winter and summer menu, which has been reviewed by a dietitian (dietitian report sighted). Meals are served directly by their staff to the residents in the main dining area via hot boxes. Meals are delivered to the McKenzie and Glenedin wings via bain maries. Healthcare assistants serve the residents' meals in these areas.</p> <p>The food service company are responsible for ensuring that all kitchen staff are trained in safe food handling and that food safety procedures were adhered to. Staff were observed assisting residents with their lunchtime meals and drinks. Diets are modified as required and likes and dislikes are catered to. Resident dietary profiles and likes and dislikes are known to food</p>

		<p>services staff and any changes are communicated to the kitchen, via the registered nurses or clinical manager.</p> <p>Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings and surveys allow the opportunity for resident feedback on the meals and food services generally. Residents and relatives interviewed indicated satisfaction with the food service.</p> <p>Snacks are supplied and available 24 hours per day in the dementia unit.</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>	FA	<p>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 to the referring agency if entry were declined.</p>
<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 nine long-term resident files sampled had interRAI assessments completed within expected timeframes. Behaviour assessments and management plans were included in the files reviewed of residents in the Glenedin (dementia wing). The respite resident had all appropriate risk assessments completed on each new admission and a care plan developed.</p> <p>A range of assessment tools are available for use on the electronic system which are completed on admission if applicable. These include (but not limited to); falls risk, moving and handling, pressure, pain, mini nutritional assessment and wound assessment. The activities coordinators and DTs complete an activities assessment. Assessments were noted to be completed on all electronic resident files reviewed and they were well linked to long-term care plans.</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>Care plans are individually developed with the resident, and family/whānau involvement is included where appropriate. All ten care plans reviewed were evidenced to be reflective of residents' current needs. Goals and outcomes were identified and agreed and how care is to be delivered was explained.</p> <p>All files sampled had an individualised long-term care plan that covers all areas of need identified. Areas covered in the resident files sampled included (but are not limited to): behaviour, social and emotional needs, cultural needs, falls risk, ADLs, nutrition and social</p>

		needs. Service delivery plans demonstrated service integration. Assessments and care plans were comprehensive and included input from allied health including geriatrician, mental health for older persons nurse practitioner, hospice dietitians, DHB wound nurse specialist, physiotherapy and podiatry.
<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 alters, the RN initiates a review and if required a GP visit. Communication to the GP when a residents' change in health status was sighted in the resident's files. Residents and relatives interviewed stated their needs were being appropriately met.</p> <p>There was one resident with a facility acquired pressure injury (resolving stage two). On the day of the audit there were twenty superficial wounds across the facility, and two chronic wounds including; one venous ulcer, and one complex fungating wound. A sample of wounds were reviewed, all had assessments, plans and evaluations showed progression or deterioration of each wound. The wound specialist nurse was involved with the chronic wounds. GPs were notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. Staff receive regular education on wound management.</p> <p>Continence products are available and resident files included urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Electronic monitoring forms in place included (but were not limited to): monthly weight, blood pressure and pulse, food and fluid charts, repositioning, blood sugar levels, wound charts and behaviour charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	CI	<p>There are three long standing members of the activities team including two diversional therapists and one activity coordinator. The activities coordinator provides activities in the rest home and hospital and one diversional therapist organises activities in the dementia unit. The diversional therapist works across both areas. There is a separate programme delivered for rest home/hospital and dementia residents. The dementia unit programme is run over seven days. All members of the activities team have completed dementia training. Care staff in the dementia unit have access to equipment and provide a variety of activities when the activities staff are not present. The activities programme caters for the needs of all levels of care provided at Radius Fulton Care Centre. Twenty-four-hour care plans are in place in the Glenedin (dementia) wing.</p> <p>During the audit, residents were observed being actively involved with a variety of activities in the</p>

		<p>hospital, rest home and the dementia unit. The programme is developed weekly and displayed in large print. All residents are given a weekly plan. Residents have a leisure and lifestyle profile assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career, and family. A plan documenting appropriate activities to support behaviour management had been completed for dementia residents.</p> <p>The programme observed in the dementia unit was appropriate for people with cognition and memory impairments. The programme includes daily exercises, small group activities and one-on-one time. Each day there are combined activities with the rest home/hospital residents, these are held either in the Glenedin (dementia) wing or in the main lounge.</p> <p>Activities are age appropriate and are planned. There are several programmes running that are meaningful and reflect ordinary patterns of life. The programme is flexible and can be changed to reflect the residents needs on the day. There are also visits from community groups. The residents continue to participate in the two weekly 'slot' at the local radio station and residents across the facility have the opportunity to participate.</p> <p>Residents provide regular feedback around their likes and dislikes of the activity programme to the activity staff, through monthly resident meetings or following activities. There is a resident action group which continues to meet on a two monthly basis and organise fundraisers such as 'wiggie Wednesday' where everyone pays to wear a wig, team quizzes and tombolas. Relatives contribute and join in the fun.</p> <p>One resident is knitting for the chemotherapy unit, the neonatal unit and refugees, they have their spot in the Radius magazine.</p> <p>Fulton Care Centre has a bid in with the Guinness Book of Records for making the longest 'forget me not' chain in association with the Alzheimer's society. Gardens from all over Dunedin donated Forget-Me-Not flowers in support.</p> <p>There are regular outings. Resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed.</p> <p>Fulton Care Centre have exceeded the standard for activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All long-term resident electronic care plans reviewed had been evaluated by RNs six-monthly, or when changes to care occurred. Written evaluations described the residents progress against the residents (as appropriate) identified goals. Short-term care plans in place for acute needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP, resident and family. The family are notified of</p>

		<p>the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The relatives interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</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>Referral to other health and disability services was evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to the needs assessment coordination service, wound nurse specialist, physiotherapist, mental health of older persons nurse practitioner (DHB), artificial limb centre and diabetic nurse.</p> <p>There is evidence of GP discussion with residents/families regarding referrals for treatment and options of care in the GP consultation notes and as documented in the progress notes by the RNs.</p> <p>Discussions with RNs identified that the service has ready access to nursing specialists such as wound specialist nurse, continence, palliative care and diabetes. The physiotherapist is employed by the organisation and is on site each week and as needed.</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>The waste management policy and procedure outlines processes. Staff were observed wearing appropriate protective clothing. All chemicals sighted were appropriately stored in locked areas and fully labelled. Staff interviewed were knowledgeable around disposing of hazardous waste.</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 service displays a current building warrant of fitness, which expires on 3 March 2020. Hot water temperatures are checked weekly. Medical equipment and electrical appliances have been tested, tagged, and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior areas are well maintained with safe paving, outdoor shaded seating and gardens. Healthcare assistants interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</p> <p>The building has been refurbished since the flooding in February 2018. The external area has a flood wall to prevent future risk of flooding. This has created new garden areas in which</p>

		<p>residents have been participating in the establishment of the gardens.</p> <p>The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required.</p> <p>The secure dementia area has an open lounge and dining area, with a quiet lounge space. All areas were well supervised on the day of audit. There are two secure outside courtyards, one on either side of the communal spaces.</p> <p>All external areas are well maintained, and all residents' wings have access to courtyard gardens and indoors with ease.</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>There are a number of hospital/rest home resident rooms, which have ensuites. The remainder of hospital, rest home and dementia residents' share communal bathrooms and toilets. There were sufficient numbers of resident communal bathrooms and toilets in close proximity to resident rooms and communal areas. The communal toilets and showers were well signed and identifiable and included large vacant/in-use signs. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity were maintained while attending to their personal cares and hygiene.</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>The resident rooms are spacious enough to meet the assessed resident needs. The rooms in the hospital wings (Brookside and Lisborne) are large and spacious, with large windows. Residents were able to manoeuvre mobility aids around the bed and personal space. All beds were of an appropriate height for the residents. Healthcare assistants interviewed reported that rooms have sufficient space to allow cares to take place. The bedrooms are personalised to each resident's individual taste, one resident has moved in their piano.</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 two main large lounge areas and a separate dining off of these in the Brookside and Lisborne wings, each wing has a smaller lounge area at the end of the wings. The dining area is spacious for residents to move around with mobility aids and is directly off the servery area. There is outdoor access throughout the communal areas.</p> <p>In the McKenzie (rest home) wing there is a smaller but airy lounge/dining area with small servery.</p> <p>The Glenedin (dementia) unit has a lounge/dining area with an adjoining small quiet lounge area.</p>

		<p>All lounge areas have outside access with no dead ends. The dining room was spacious and located directly off the kitchen/server area. All areas are easily accessible for the residents.</p> <p>The furnishings and seating throughout the facility was appropriate for the residents. Residents interviewed reported they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.</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>There was a team of dedicated cleaning staff who clean the facility (one for each wing). They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility. All chemicals and cleaning trolleys are stored in locked cupboards when not in use.</p> <p>All laundry is done on site in the commercial laundry by dedicated laundry staff. There was a clear dirty to clean pathway, protective equipment was utilised, and a closed system was in place for chemicals. Residents and relatives interviewed were satisfied with the laundry service.</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>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. 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. Civil defence kits were also in place. Supplies of stored water (2800 litres) and food were held on site and were adequate for a minimum of three days. Two generators are available on site. Electronic call bells were evident in resident's rooms, lounge areas and toilets/bathrooms. The facility is kept locked from dusk to dawn.</p> <p>The facility has demonstrated evidence of effective and efficient resident evacuation procedures from flooding, resulting in a rating of continuous improvement.</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</p>	FA	<p>All communal spaces and resident bedrooms have external windows with plenty of natural light. General living areas are heated with underfloor heating and resident rooms are appropriately heated with adjustable panel heaters and well ventilated. Residents and relatives interviewed stated the environment was warm and comfortable.</p>

and comfortable temperature.		
<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>	FA	<p>Radius Fulton Care Centre has an established infection control programme. The infection control programme, its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical manager is the designated infection control nurse. The infection control programme is companywide and has been reviewed annually at Radius head office. Visitors are asked not to visit if they are ill and are notified if there are infections within the facility and reminded of good practice.</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>	FA	<p>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control nurse maintains practice by undertaking the MOH online training and attending SDHB infection control study days. The infection control committee is made up of the infection control nurse and heads of departments. Infection control meetings are held at staff meetings, so everyone is involved with infection control including clinical and non-clinical staff such as maintenance, cleaning and laundry staff.</p> <p>The infection control nurse has access to external support from the Public Health South, southern community laboratories, DHB nurses and the Radius infection control team who are readily available. Staff interviewed were knowledgeable regarding their responsibilities for standard and additional precautions.</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>Fulton Care Centre uses the Radius group infection control policies and procedures. The policies and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred according the education schedule. During the winter months there have been tool-box education sessions on respiratory</p>

<p>service providers, support staff, and consumers.</p>		<p>etiquette. Throughout the year there are similar toolbox sessions held on topical subjects of the time. The infection control nurse accesses the MOH tool for topical information around, for example, influenza.</p> <p>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 their 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>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated weekly, monthly and annually. Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the village manager and support office staff.</p> <p>There have been no outbreaks since November 2017. An employed member of staff was identified having tuberculosis in April 2019 and Public Health South was contacted, and contact tracing was completed. This was well managed and documented, and all staff and residents were updated regularly.</p> <p>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.</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>A registered nurse 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.</p> <p>There were nine (hospital level) residents using enablers (bedrails) and two (hospital level) residents using bedrails as restraint during the audit.</p> <p>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</p>

		<p>was regularly reviewed.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <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>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<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>Consultation with the resident and/or family/whānau were evident in the file reviewed where restraint (bedrails) were in use. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<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 resident's file 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</p>

		<p>for the resident's file 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</p> <p>Services evaluate all episodes of restraint.</p>	FA	<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>	FA	<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>

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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	CI	<p>The achievement of the rating that service implements a robust corrective action planning process is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of corrective actions has occurred. There is evidence of action taken based on corrective actions that has made improvements to service</p>	<p>Two corrective action plans implemented addressing residents' falls, have resulted in a rating of continuous improvement:</p> <p>1) Falls trending identified an increase in the frequency of falls occurring over the lunch hour over the period of March – May 2019, with ten falls recorded. Strategies implemented by staff including (but not limited to) staggering lunch times for staff, allowing for better staff cover during mealtimes. In addition, they completed a review of the literature on interventions to prevent falls and reduce harm from falls. Other interventions have included the use of vitamin D, falls graphs which reflect the time and day of falls, ongoing training in falls prevention, separation of monthly meeting process to ensure there is a team approach for reducing falls for at risk residents, introduction of 'jazzercise' class by the physio in addition to the steady as you go programme, contracted physiotherapy hours have increased, reviewed with staff the role of hydration in falls prevention, and the reintroduction of action plans for frequent falls. All this has resulted in a corresponding reduction in the number of falls (four falls over the lunch hour from June – Aug 2019).</p> <p>2) A second corrective action implemented addressed reducing harm from falls. In 2017 a new supplier of hip protectors was introduced for residents at risk of falls. These hip</p>

		provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction.	protectors have been promoted and encouraged. Twenty residents who were identified at risk of falling, currently wear hip protectors compared with four residents in 2017 and eight residents in 2018. The number of fractures from falls has reduced from five (2017) to two (2018) and only one (year to date) for 2019.
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	The activities team set themselves a goal of encouraging all residents to try something they have never done before, providing inter-generational activities, to provide opportunities to be part of an increasing the combined activities throughout the care centre.	The 2018 resident survey identified resident satisfaction was around 45%. Comments were analysed around what people liked and what they wanted more of, for example, more activities over the weekend, and several comments around liking the musical activities. It was identified through the survey that a high number of residents across the facility enjoy music, and music was often used in the Glenedin wing to soothe resident anxiety. The music for the dementia programme was introduced by a relative who provided information for other families to consider, this has been disseminated across the facility. The programme is run by an external organisation, who follow up with families who are interested or who have been liaising regarding the benefits of the programme. The organisation then proceeds by gathering information about the person's musical likes and dislikes and loads the music onto headphones. Music therapy and music appreciation is used throughout the home for many who are not on the programme, such as one-on-one time. There are different forms of musical activities such as musical quiz, music and movement, sing-alongs with a resident playing the piano, and an external speaker visits on a six weekly basis who researches music and composers and presents this to the residents and plays the music. This links with the Residents Radio show, which has attracted entertainers to the facility to entertain. The 2019 satisfaction survey showed a further 20% increase on 2018 of residents very satisfied with the programme. During the audit there was a variety of musical entertainment on offer with many residents participating.
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to	CI	Procedures implemented to effectively manage residents during a flood has resulted in a rating of continuous improvement.	The facility experienced their first flood with evacuation of 50% of the residents on 4 June 2015. Lessons learned from this experience resulted in enhanced processes around resident evacuations during a second flood on 1 February 2018 where 100% of the residents had to be evacuated. Interviews with managers, HCAs and the designated emergency team (three managers, three HCAs, three RNs, activities coordinator, maintenance staff) demonstrated that the lessons learned during the first evacuation in 2015 resulted in a more efficient

<p>respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>			<p>evacuation of residents in 2018. Examples provided included that during the flood in 2018, alerts were in place notifying residents and staff more quickly. Support by external providers (eg, transporting residents) was also expedited more quickly. A triage system was implemented where the more acute residents were evacuated first. Only significant and pertinent information (in hard copy) accompanied the resident (during the first flood the entire resident folder was copied). Residents now wear wrist bands for identification purposes. HCAs reported that they were able to manage residents' stress levels better because they knew what was happening and were familiar with evacuation processes. They visited residents while they were staying in other aged care facilities and the re-admission process back to Radius Fulton Home went smoothly with GP visits and interRAI assessments all taking place within acceptable timeframes.</p> <p>Construction has been undertaken to prevent future flooding and the need for evacuation through the use of underground water storage tanks.</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>Following exposure to TB in April 2019, the staff of Fulton Care Centre identified the further risk of exposure to infections with the increased risk of an influenza outbreak during the winter months and set a goal of maintaining good infection control practices to maintain low infection rates and meet KPI targets.</p>	<p>On reviewing the 2018 data, it was identified that during the winter months KPIs were not met around infection rates. The infection control nurse continued to monitor all infections and effectiveness of treatments on a weekly basis. Monthly data continued to be collated and analysed. Staff and residents were encouraged to have the flu vaccine, which resulted in the staff uptake of 87% and 96% of residents. A monthly electronic dashboard for infection rates was commenced. Added signage reminding visitors and staff around reducing the spread of respiratory infections was displayed, tool-box sessions on respiratory etiquette were held.</p> <p>Radius Fulton Care Centre have had no outbreaks since 2017, KPI around infection control has been met for the last 12 months. The infection control nurse presented two case studies on the effectiveness of medications for prevention of urinary tract infections. The infection control nurse follows the flu tracker on the MOH website. To date no staff or residents have had signs or symptoms of influenza.</p>

End of the report.