

Radius Residential Care Limited - Radius Glaisdale

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 BSI Group New Zealand Ltd, 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 Glaisdale

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: 11 March 2021 End date: 12 March 2021

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: 76

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 Glaisdale is owned and operated by Radius Residential Care Limited. The service provides rest home, hospital, and dementia level of care for up to 80 residents. On the day of the audit there were 76 residents.

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

The service is managed by a facility manager (registered nurse) with previous experience in aged care clinical management. The facility manager is supported by a Radius regional manager, Radius operations manager and a clinical manager. Since the last audit, the service has made some environmental changes to support staff handovers and workflow, family visiting during Covid-19 pandemic and for external providers to continue to provide services during lockdown. Staffing has been increased in response to acuity of residents. The service has also rolled out an electronic human resource system.

Residents, relatives, and the general practitioner interviewed spoke positively about the service provided.

This audit has not identified any areas for improvement.

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. |
|--|--|--|

Radius Glaisdale practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights 'the Code' and copies of the code are displayed throughout the facility. There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents, and family verified the service is respectful of individual needs, including cultural and spiritual beliefs. There are implemented policies to protect residents from discrimination or harassment. There is a complaints policy supporting practice and an up-to-date register. Staff interviews confirmed an understanding of the complaints process.

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. |
|---|--|--|

There are organisational-wide processes to monitor performance, with additional support provided to assist this new facility. The service is managed by appropriately trained personnel and there is a suitable structure in place to oversee service delivery in the absence of the manager. There is an adverse event reporting system implemented. Monthly data collection and analysis is undertaken, and results are made known to staff.

There is a human resource manual to guide practice. Staff files were reviewed, and all had a current appraisal and showed human resource practices are followed. There is a documented rationale for staffing the service. Staffing rosters were sighted and

healthcare assistant staff on duty match needs of different shifts and individual resident needs. Resident information is kept confidential and old records are archived.

Continuum of service delivery

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

Entry to the service is managed primarily by the facility manager/registered nurse. There is comprehensive service information available on the three service levels of care. Initial assessments are completed by a registered nurse. Care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans and worklogs (developed on the electronic resident system) are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process. The general practitioner reviews residents at least three monthly. There is allied health professional involvement in the care of the residents.

The activity programme is varied and interesting and includes outings, entertainment, and links with the community. Each resident has an individual leisure care plan. The rest home and hospital have an integrated programme. The activities in the dementia unit are flexible and meaningful.

Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Medications are prescribed and administered in line with appropriate guidelines and regulations.

Meals and baking are prepared on site by a contracted service. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. There are nutritious snacks available 24 hours.

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. |
|--|--|--|

The building has a current certificate for public use. There is a reactive and maintenance plan. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy with ensuites. There are communal toilet/showering facilities available. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are lounge and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas for each area are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. There is at least one staff member on duty at all times with a first aid certificate.

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. |
|---|--|--|

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were two residents with restraints during the audit. There were no residents requiring an enabler at the time of audit.

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.

There are infection control management systems 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. The infection control coordinator has attended external education. 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.

Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 101 | 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 |
|--|-------------------|--|
| Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation. | FA | Radius Glaisdale has an implemented code of rights policy and procedure. Discussions with staff included five healthcare assistants across all levels of care and all shifts; four registered nurses including two clinical team leaders; household staff including two cleaners, one pest control provider, one chef; maintenance staff; and three activity coordinators. The audit team also interviewed the regional manager, clinical manager (CM), office manager, and facility manager. All interviewed confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights 'the Code'. Interviews with 10 residents (five hospital including one funded under an ACC contract, and five rest home) and nine relatives (five hospital, two dementia and two rest home) confirmed that the service is provided in line with the Code. |
| Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make | FA | Informed consent processes are discussed with residents and families on admission. Consent forms, advance directives, and copies of enduring power of attorney (EPOA), where applicable, were seen on each individual electronic resident database (eCase) in the nine resident files reviewed (three rest home including one using respite services, three hospital including one under an ACC contract, and three dementia level of care residents). There is evidence of general practitioner discussion with family regarding resuscitation, as evidenced in the eCase progress notes. EPOA are activated when required. |

| | | |
|--|-----------|--|
| <p>informed choices and give informed consent.</p> | | <p>Healthcare assistants and registered nurses (RNs) interviewed confirmed verbal consent is obtained when delivering care. This was observed as occurring during the audit. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>All nine resident files reviewed had a signed admission agreement completed on entry to the service.</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>There is an advocacy policy and procedure that includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy and advocacy pamphlets are available at reception. Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.</p> <p>The resident file includes information on resident's family/whānau and chosen social networks.</p> <p>Discussion with relatives identified that family/enduring power of attorney (EPOA) are involved in decisions and they are happy with the level of involvement currently.</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>The client information pack informs that visiting can occur at any reasonable time. Interviews with residents and relatives confirmed that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans.</p> <p>The service supports each resident to maintain relationships with their family, friends, and community groups. This includes encouraging them to attend functions and events and helping to ensure that they are able to participate in as much as they can safely and desire to do.</p> <p>Resident meetings are held two-monthly, and family can participate if they wish to. Staff particularly encourage family members from the dementia unit to engage in the meetings. Regular Radius newsletters are provided to residents and relatives with copies available in the library on site. There is evidence of sound communication with family members and residents throughout the Covid-19 pandemic lockdown periods.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and</p> | <p>FA</p> | <p>The complaints policy and procedure states that clients/family/whānau shall have access to a complaints system whereby they can express concern without prejudice and those concerns are addressed. Residents/family can lodge formal or informal complaints through verbal communication, written, resident meetings, and complaint forms or via suggestion box. Information around the complaints process and forms are included in the information pack provided to residents and relatives at entry.</p> <p>The complaints log/register includes date of incident, complainant, summary of complaint, and sign-off as</p> |

| | | |
|--|----|--|
| upheld. | | <p>complete.</p> <p>There have been three complaints in 2020 and two in 2021 year-to-date. One complaint in 2020 was escalated to the district health board (DHB). The complaint related to further information required by the family member around the call bell system, and this was closed out by the DHB with actions taken to improve the system (monitoring systems for time taken to respond to call bells, monthly call bell checks, and a documented timeframe for responding to, and escalating of unanswered call bells).</p> <p>Another complaint related to all aspects of care was followed up verbally with one family member and closed out initially. A second complaint from a separate family member around the same aspects of care was escalated to the Health and Disability Commission. Extensive documentation and involvement of the family resulted in resolution of the complaint with sign off by the HDC, DHB and the family who were also happy with the outcome.</p> <p>One other complaint was reviewed. Timeframes for responding to the complainant and resolution of issues raised was as per the policy and the Code.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>The service provides information to residents that includes the code of rights, complaints, and advocacy information. Information is given to next of kin or EPOA to read to and/or discuss with the resident. Interviews with residents and relatives identified they are well informed about the code of rights. There is a specific information pack for families and residents in the dementia unit.</p> <p>The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet, advocacy, and Health and Disability Commission information. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</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>The service has a philosophy that promotes quality of life and involves residents in decisions about their care, respects their rights and maintains privacy and individuality.</p> <p>Contact details of any spiritual/religious advisors are available to staff. Religious dietary requirements identified through assessment and care planning are met as required. Discussions with residents and relatives confirmed the staff are respectful and that their privacy is respected, and that cultural and/or spiritual values and individual preferences are identified. Care plans reviewed identified specific individual likes and dislikes. There have not been any incidents related to abuse or neglect in the past year. The general practitioner (GP) praised the service for the way services were delivered and stated that there was no evidence of abuse or neglect.</p> |

| | | |
|---|----|--|
| | | <p>There is an implemented abuse and neglect policy that staff have completed training around as part of orientation and could describe appropriate practices to prevent and identify any abuse or neglect. Ongoing training is planned and provided, as part of the Radius annual training plan.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | FA | <p>There is a specific Māori health care plan and a culturally safe care policy. The service has four residents who identify as Māori. They have a culturally appropriate care plan. There are four staff who identify as Māori. Staff interviewed described speaking in te reo Māori when possible (eg, to greet someone who was Māori and noted that Māori staff interacted with Māori residents using te reo Māori). One resident was visibly noted to calm down when staff spoke to them in Māori.</p> <p>Discussions with staff confirmed an understanding of the different cultural needs of residents and their whānau. There is a section in the electronic assessment and care plan that includes spirituality, religion and culture, psycho-social needs and family and significant others and a specific Māori health assessment and plan. Three of the four records for residents who identified as Māori were reviewed and all included reference to needs, values and preferences using the Whare Tapa Whā model to identify cares and support required.</p> <p>The activity staff have worked with three local marae and a Kaupapa Māori provider to identify local supports and programmes for residents to link into. They have identified online training and resources for staff to access and the programme to improve services for Māori residents and whānau is currently being implemented.</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>Care planning includes consideration of spiritual, psychological, and social needs. Residents indicated that they are involved in the identification of spiritual, religious and/or cultural beliefs. Relatives interviewed stated that they felt they were consulted. Family involvement is encouraged (eg, invitation to facility functions).</p> <p>A Chinese resident was interviewed with the help of a Mandarin speaking staff member who acted as an interpreter. The Chinese resident, with very limited English said communication was very good and they were well supported. The resident interviewed had communication cards in Mandarin and in English for common phrases and cares. These were attached to the resident's mobility aid and were observed to be used regularly by staff. Care staff interviewed also stated that they were learning phrases starting with common greetings.</p> <p>Care plans reviewed included the residents' social, spiritual, cultural, and recreational needs.</p> |

| | | |
|--|-----------|--|
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | <p>FA</p> | <p>There is a comprehensive and implemented discrimination and harassment policy in place. Job descriptions include responsibilities of the position and ethics, advocacy, and legal issues. The comprehensive orientation programme provided to staff on induction includes dignity and privacy. Interviews with staff informed an understanding of professional boundaries. A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. There is a staff policy in relation to gifts and gratuities and the management of external harassment. Interviews with healthcare assistants confirmed their understanding of professional boundaries, including the boundaries of the HCAs role and responsibilities.</p> <p>Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned. A staff employment handbook and orientation package includes training around professional boundaries.</p> <p>Residents interviewed felt that they were not exposed to exploitation.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | <p>FA</p> | <p>Services are provided at Radius Glaisdale that adhere to the Health & Disability Services Standards (2008) and all required legislation and guidelines are adhered to. The service has implemented policies and procedures to provide assurance it is adhering to relevant standards. Policies are reviewed and approved by the clinical management committee at an organisational level. The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility.</p> <p>Staff are informed when external training is available and financial support is considered. There is support available for those wishing to pursue postgraduate qualifications (appropriate to the area of work). There is access to computer and internet resources and search engines.</p> <p>The service has embedded the quality and risk management programme. There are comprehensive action plans in place, service support from a senior team and additional education and support provided for staff. The service has reviewed a number of practices and systems and as a result has improved service delivery. Additional staff have been added in response to the increased acuity of residents at hospital level of care; the introduction of a new clinical team leader role that supports care staff on the floor; providing senior registered nurses with more responsibilities as opposed to the clinical and facility managers holding all portfolios (eg, allocation of oversight and monitoring of the infection programme to a clinical team leader).</p> <p>The service has responded to the Covid-19 pandemic well with communication to family and residents relevant to public health directives, extra staff training in use of personal protective equipment and infection control measures, and to ensure that the creation of a family/whānau room that allowed family to</p> |

| | | |
|---|----|--|
| | | <p>enter the service relevant to changes in levels directed by public health, in a safe manner.</p> <p>A new electronic human resource (HR) system has been being rolled out and all HR related information is kept in one source (electronic). Access is restricted to specific staff who need to use or upload the information with filters at facility level to ensure privacy for staff.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Twenty incident reports were reviewed across the service and all recorded family notification. Relatives interviewed confirmed that they were notified of any changes in their family member's health status or of any incident.</p> <p>The facility has an interpreter policy to guide staff in accessing interpreter services. Interpreter services are available if needed. Staff and family are utilised in the first instance. There are two residents who currently require an interpreter and family fulfil this role along with translation cards and staff who can interpret. The service is able to access the district health board interpreting services if required. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health 'Long-term Residential Care in a Rest Home or Hospital – what you need to know' is provided to residents on entry. The information pack is available in large print and advised that this can be read to residents. The information pack and admission agreement included payment for items not included in the services. A site-specific booklet: 'Introduction to dementia unit' provides information for family, friends, and visitors to the facility. The enquiry pack provides practical information for residents and their families.</p> <p>The staff provide residents with individualised care with special attention paid to preferences, choices, responses followed up to suggestions and to values.</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</p> | FA | <p>Radius Glaisdale is a purpose-built Radius aged care facility that opened June 2017. The facility is certified to provide hospital services (medical and geriatric services), rest home care and dementia care for up to 80 residents. On the day of the audit there were 76 residents. The 60-bed rest home and hospital (all dual-purpose beds) included: 32 hospital level residents (including two residents under an ACC contract) and 24 residents at rest home level including one under respite care. The 20-bed secure dementia unit included 20 residents.</p> |

| | | |
|---|-----------|--|
| <p>consumers.</p> | | <p>The service has a business plan that describes the vision, values, and objectives, which includes a person-centred approach. This includes the Radius philosophy that identifies the provision of safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. Review of the business plan, quality plan and action plans reflect regular reviews via regular meetings and monthly reports to the regional manager. The regional manager discusses the reports at senior management level and that is then forwarded to the monthly Board meetings.</p> <p>The regional manager meets the clinical managers and facility managers from all five of their facilities fortnightly on site, and there are zoom meetings on alternative weeks. Radius have also introduced a monthly zoom meeting with facility managers, clinical managers, and office managers to discuss upcoming events, trends, topical issues, and any changes to the company.</p> <p>The regional manager has been with Radius for eight years, had over 16 years' experience in management of aged care facilities, holds a Master's in Nursing with a focus on clinical leadership, and is a registered nurse. The facility manager has been in the role for a year, has over eight years' experience as a team leader in a separate aged care facility and has also had clinical manager experience. The clinical manager has been in the role for over a year, and they have over 11 years' experience in aged care.</p> <p>The facility, clinical and office managers are enrolled in the level 4 first line managers programme offered by the local polytechnic. All managers 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> | <p>FA</p> | <p>During the temporary absence of the facility manager, the service is managed by the regional manager with support from the clinical manager and the clinical team leaders. If the clinical manager (CM) is on leave, then the clinical team leaders will take on the role of CM with support from the facility manager and regional manager, all of whom are RNs. Radius has roving clinical managers and roving managers who can provide support during absences as well.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p> | <p>FA</p> | <p>There is a business plan 2020 to 2021 that has been reviewed quarterly with results escalated to the regional manager and then to the board. There is a quality/risk management plan that includes clinical/care related risks, human resources, health and safety, environmental/service, financial as well as site-specific risks/goals identified. Quality indicators are reported monthly with benchmarking against key</p> |

| | | |
|---|-----------|--|
| <p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | | <p>indicators occurring.</p> <p>There are policies and procedures appropriate for service delivery. Policy manuals are reviewed two yearly. New/updated policies are sent from head office. New policies/procedures are put in the staffroom with a signing sheet for staff to sign once they have read and understood the documentation.</p> <p>Quality data including collection of monthly accident/incident and infection surveillance data, resident/relative surveys and internal audits are conducted, and corrective action plans are developed and implemented when service shortfalls are identified. There are regular quality meetings that include all aspects of the quality and risk management programme (ie, health and safety, internal audits, incidents and accidents and infection control). Registered staff and staff meetings have been held with quality data and corrective action plans also discussed at these meetings. Resident/relative meetings are held two monthly.</p> <p>There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The health and safety representative interviewed confirmed knowledge of the health and safety programme and their support for staff. The health and safety representatives include the facility manager, a healthcare assistant who is enrolled in training for health and safety and three representatives who have completed at least level one training. Staff and contractors are orientated to health and safety issues and staff. The health and safety team identify and report hazards on hazard forms, which are then eliminated or minimised and added to the regularly reviewed hazard register.</p> <p>Falls prevention strategies for individual residents such as sensor mats, low beds, landing mats, specialised chairs and intentional rounding are implemented and were described by staff interviewed.</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> | <p>FA</p> | <p>When an incident occurs the healthcare assistant (or staff discovering the incident) completes the form and the RN undertakes an initial assessment and logs the incident onto the electronic system. The RN notifies family and GP as required with this documented in all 20 incident forms reviewed. The clinical manager collects incident reports daily and reviews both the incident and actions taken. There is evidence of proactive follow-up to incidents reviewed for 2021. All twenty incident forms sampled evidenced detailed investigations and corrective action plans following incidents. Incident reports are discussed daily at management updates and at monthly quality meetings.</p> <p>The staff interviewed could describe the process for management and reporting of incidents and accidents.</p> <p>Discussions with the regional manager and facility manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. Notifications have been made around two pressure injuries (both for one resident), and three for challenging behaviour with two of the three for</p> |

| | | |
|--|----|--|
| | | the same incident. The service links closely with the DHB. |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | FA | <p>Eight staff files were reviewed (clinical manager, clinical team leader, two registered nurses, three healthcare assistants, one activities person). All files reviewed had appropriate employment and human resource documentation, including interview and reference check documentation, employment contracts and job descriptions. There is a register for staff competencies that shows all competencies are current. Practising certificates were sighted for registered nurses, GPs, physiotherapist, pharmacy, podiatrist, and dietitian.</p> <p>The organisation has a staff orientation policy. All staff files documented an orientation programme that is specific to worker type. Staff interviewed confirmed that all staff employed have an orientation period and that this is extended if required. The service has an internal training programme directed by head office that covers all required topics. The service has provided a wide range of additional training and toolbox talks related to issues raised by incident forms, complaints and any other service gaps identified.</p> <p>There are 10 healthcare assistants (HCAs) who work in the dementia unit and all have completed the required dementia standards. There are 10 other HCAs in the process of completing their dementia training and they provide cover when staff are away in the dementia unit.</p> <p>Registered staff are supported to attend internal and external training to maintain current practice. Of the 11 registered nurses, five are interRAI trained.</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> | FA | <p>There is an acuity and clinical staffing ratio policy in place that includes a documented rationale for staffing the service. The facility manager and clinical manager are registered nurses, work full time and share on-call responsibilities. Additional support is also provided by a regional manager (Monday to Friday) and two clinical team leaders who have recently been appointed into their role.</p> <p>Staffing in each unit is as follows:</p> <p>Dementia unit: Currently 20 of a potential 20 residents. On morning shifts, there are two healthcare assistants who work a full shift. On afternoon shifts, there are two healthcare assistants with one working a full shift and one a short shift. On night shift, there is one healthcare assistant.</p> <p>Hospital wing: Currently 36 of a potential 40 residents (32 hospital and 4 rest home residents). On morning shifts, there are six healthcare assistants with four who work a full shift and two who work a short shift. On afternoon shifts, there are five healthcare assistants with three working a full shift and two a short shift. On night shift, there are two healthcare assistants.</p> <p>Rest home: Currently 20 residents. On morning shifts, there are two HCAs who work full shifts. On</p> |

| | | |
|--|----|--|
| | | <p>afternoon shifts, one healthcare assistant works a full shift and one a short shift. On night shift, there is one healthcare assistant.</p> <p>There are two RNs on the morning with one in the hospital and one between the rest home and dementia unit. There is also a clinical team leader (registered nurse) who works four days a week with an ability to increase their support to five days a week if required. There are two registered nurses on afternoon shift and one overnight.</p> <p>In response to a greater acuity and number of hospital residents, the facility and clinical managers have added additional staff. There was a floater between the hospital and rest home in the past. This position is now permanent with the HCA placed in the hospital wing in the afternoon. There is also a short shift added in the afternoon in the rest home.</p> <p>Staff interviewed stated that there is adequate staffing to manage their workload. When staff are absent, and a replacement cannot be found from the current staff, agency staff are used. The facility manager stated that staff can increase with acuity and/or resident numbers.</p> <p>There is a physiotherapist employed 12 hours a week.</p> <p>Residents interviewed confirmed that there are sufficient staff on site at all times and staff are approachable, competent, and friendly.</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>There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual electronic record and service register.</p> <p>Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Informed consent is obtained from residents/family/whānau on admission, for permission to display the resident's name and taking of photographs.</p> <p>Entries in resident files sampled were legible, dated and have an electronic signature by the relevant caregiver or RN including designation. All resident records contain the name of resident and the person completing the form/entry.</p> <p>Individual resident files demonstrated service integration that also contains GP notes and the allied health professionals and specialist's records if applicable.</p> |
| Standard 1.3.1: Entry To | FA | The service has comprehensive admission policies and processes in place. Residents receive a welcome |

| | | |
|--|----|--|
| <p>Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | | <p>pack outlining services able to be provided, the admission process and entry to the service. The welcome pack includes specific information on the secure dementia care unit "welcome to our secure wing". There is also information for families from Dementia New Zealand.</p> <p>The facility manager/registered nurse or clinical manager screens all potential residents prior to entry to ensure the service can meet the assessed need and support required. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager. The admission agreement aligns with the requirements of the ARCC. Exclusions from the service are 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>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. Residents in hospital or on social leave are identified and monitored through the eCase resident database.</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> | FA | <p>The medication management policies and procedures comply with medication legislation and guidelines. Registered nurses and level 4 HCAs administer medications and have completed medication competencies and medication education. Registered nurses complete syringe driver training. Medications are delivered in robotic rolls for regular and 'as required' medications. These are checked against the paper-based medication charts and signed off on the pharmacy record. All medications are stored safely throughout the facility. There is daily monitoring of the medication fridge and daily monitoring of the medication room air temperature. Both temperatures were within the acceptable ranges. All eyedrops were dated on opening. There is a hospital stock available which is checked regularly for expiry dates. There was one respite care resident self-medicating on the day of audit. There was a self-assessment competency completed.</p> <p>Eighteen medication charts (paper-based) reviewed (six hospital, six rest home and six dementia care) met prescribing requirements for regular and 'as required' medications. Photo identification and allergy status had been identified on all charts. Digoxin monitoring charts had been completed as required. There were no standing orders used but telephone orders are taken and witnessed by a RN and another medication competent person. Telephone orders sighted had been signed by the GP within the required timeframe.</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>There is a fully functional kitchen located within the service area of the building. All food and baking is prepared and cooked on site by a contracted service. The co-owner/director (interviewed) visits the site fortnightly. The chef/kitchen manager has been employed since February and holds a diploma in hotel management and a level four cookery qualification. The chef/kitchen manager is supported by a second chef and kitchen assistants who have all completed food safety training.</p> <p>The co-owner/director develops the menu plan which is then reviewed by Dietitians NZ. Recipes and ordering is done online. There is a four-weekly winter and summer menu that includes a vegetarian option. Pureed foods, diabetic desserts, food allergies, likes and dislikes are accommodated. There is special equipment available for residents if required. Meals are plated and delivered in hot/cold boxes (as applicable to the unit kitchenettes). End-cooked temperatures and hot/cold box temperatures are monitored. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. The chef is notified of any changes to resident's dietary requirements.</p> <p>The temperatures of refrigerators, freezers and chiller are monitored and recorded twice daily. The chemical provider checks and monitors the performance of the dishwasher. All food is stored appropriately and dated. A cleaning schedule is maintained. The current food control plan was issued 23 August 2017.</p> <p>Residents and the family members interviewed commented positively about the quality and variety of food served.</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 decision to the potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</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>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Information received from hospital discharge, homecare interRAI assessments and GP medical notes is used to develop the initial interim care plan within 24 hours. Appropriate assessment tools have been completed on eCase and reviewed at least six monthly or when there was a change to a resident's health condition, in files sampled.</p> <p>Behavioural assessments have been completed in the records for the three residents reviewed using</p> |

| | | |
|--|----|---|
| | | dementia level of care. Electronic care plans are developed on the outcomes of these assessments. A resident's life story and activity assessment is also completed for all new residents with these sighted in files reviewed. InterRAI assessments had been completed for new residents within 21 days and are utilised as part of the six-monthly evaluation of care plans. |
| <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>Long-term care plans reviewed on the eCase described the support required to meet the residents' goals as identified by the ongoing assessment process. The long-term care plans reflected the outcomes of risk assessment and interRAI assessments. There were care plans developed for specific medical conditions such as diabetes and risk plans. Behaviour management plans had been completed for residents with dementia. Residents and their family/whānau confirmed they are involved in the care planning and review process. The electronic progress notes evidenced resident/relative involvement in care planning and reviews. The respite care resident had a treatment plan in place developed by the rest and recuperation team (social worker, occupational therapist) at the DHB. The team follow up the resident on days five and nine.</p> <p>Allied health involvement was linked to the long-term care plans. Staff interviewed reported they found the plans easy to follow and readily available.</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>Registered nurses (RNs) and HCAs follow the detailed and regularly updated care plans and report progress against the care requirements each shift. If a resident's health status changes the RN initiates a GP or nurse specialist review. Relatives interviewed stated they are contacted for any changes in the resident's health including accidents/incidents, infections, GP visits, appointments, medication changes and transfers to hospital.</p> <p>Staff have access to sufficient medical supplies including dressings. Wound assessment and care plans, wound review plans and evaluation notes were in place for 16 hospital, one rest home and two dementia care residents with wounds (skin tears, two surgical wounds, scrapes, and abrasions). There were three stage one pressure injuries (two facility acquired and one on admission), two stage two pressure injuries both facility acquired, and one resident with two unstageable facility acquired pressure injuries. All residents with pressure injuries are hospital level. A section 31 was sighted for the unstageable pressure injuries. There were sufficient pressure relieving devices available including air alternating mattresses, foam booties and cushions. Monitoring charts evidenced two hourly repositioning as instructed on the work logs. Care plans described pressure injury interventions for residents at risk and with pressure injuries. Staff had received education on wound care and pressure injury prevention. One RN is the wound nurse for the service and there is specialist nursing wound care management advice through the DHB wound nurse.</p> |

| | | |
|--|-----------|--|
| | | <p>There are sufficient continence products available and resident files reviewed included a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Electronic monitoring forms are completed and reviewed by the RN for progress against short term needs and supports. Monitoring charts include bowel charts, blood pressure, weight charts. blood sugar levels, food and fluid charts, fluid balance charts, turning charts, behaviour charts, pain monitoring, neurological observations, and restraint monitoring.</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> | <p>FA</p> | <p>There is a team of three activity coordinators who rotate across the rest home, hospital, and dementia unit from Monday to Friday each week. They have completed the unit dementia standards and have current first aid certificates. There are three activity coordinators on Monday and Tuesday and two on the rest of the weekdays. There are monthly planners for the rest home/hospital integrated activity programme and the dementia care unit. The programmes commence from 9 am to 3.30 pm. Integrated activities take place in the large hospital lounge and residents from the dementia care unit are invited to attend (as appropriate and under supervision).</p> <p>The rest home/hospital programme includes (but not limited to); exercises – circuit and stand tall balance class, quiz and word games, crafts, armchair travel, table games and puzzles, bingo, movies and sing-a-longs and carpet bowls. Room visits, and one-on-one time is spent with residents who choose not to join in with group activities. There are two walking groups to meet the differing physical needs of the residents from all the levels of care. The walking groups were observed going out to enjoy the fresh air and gardens on the day of audit. The dementia unit residents were well supervised.</p> <p>The dementia unit activity programme is designed to meet small group (eg, baking, crafts) and individual activities (eg, hand pampering). The programme is flexible and includes sensory activities.</p> <p>The van for outings has two wheelchair spaces. There are fortnightly scenic drives, outings and café visits for rest home/hospital residents and there are weekly outings for dementia care residents to places of interest/scenic drives.</p> <p>Community visitors include entertainers, family volunteers, church services, visiting kindergarten children and school children and pet therapy. Festive occasions and special events including birthdays are celebrated.</p> <p>All resident files reviewed have an individual recreational assessment and leisure plan that is evaluated at least six monthly. Residents and families interviewed commented positively on the activity programme. Residents have the opportunity to feedback on the activity programme through resident meetings and surveys.</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 initial interim care plans are evaluated by the registered nurses within three weeks of admission and at least six monthly thereafter. Care plans are updated with other changes as they occur. A multidisciplinary conference is held (MDT) involving input from resident (as appropriate), relative, care staff, physiotherapist, GP, and other allied health professionals involved in the care of the resident. There is a record of the MDT meeting which records if the resident goals have been met or not. There is at least a three-monthly review by the GP.</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>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on electronic resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs and responded to in a timely manner. Referrals and options for care were discussed with the family as evidenced in interviews and eCase medical notes. There is close liaison and good communication with dietitians, physiotherapists, podiatrist, mental health service for the older person, assessment and rehabilitation team, ophthalmology, diabetes service and the DHB rest and recuperation team which was sighted in electronic resident files reviewed.</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 implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available. Staff have completed chemical safety training.</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</p> | <p>FA</p> | <p>The single storey building has a building status of compliance certificate declaring all emergency systems are safe and compliant. A building warrant of fitness not issued as monthly checks were not completed during the level4 lockdown period in 2020. The maintenance person (based at another Radius site) is on site two mornings a week at Glaisdale. Repairs and maintenance requests are generated through the eCase maintenance log, which is then actioned and logged. Monthly planned maintenance is completed as per the planned maintenance schedule including building warrant of fitness checks and hot water temperatures. All clinical equipment and electrical equipment is tagged, tested and calibrated annually.</p> |

| | | |
|---|-----------|---|
| <p>purpose.</p> | | <p>The maintenance person is available to visit the site at any time for facility matters and is on-call. Essential contractors are available 24 hours.</p> <p>The facility has wide corridors and rails for residents to mobilise safely using mobility aids. The external areas and courtyards are well landscaped. Residents have access to safely designed external areas that have seating and shade.</p> <p>The dementia unit has a spacious secure outdoor courtyard with a safe walking pathway that has several entry/exit doors. Seating and shade is provided.</p> <p>Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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> | <p>FA</p> | <p>All bedrooms have full ensuites. There are adequate numbers of toilets located near communal areas. There is a large shower room in the hospital that can accommodate a shower trolley if required. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</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> | <p>FA</p> | <p>All resident rooms are single. There are 60 dual-purpose rooms that are of an appropriate size to allow rest home or hospital level of care. There is sufficient space for the safe use and manoeuvring of mobility aids and hoists. Resident rooms in the 20-bed dementia care unit are spacious. 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,</p> | <p>FA</p> | <p>There are open plan dining and lounge areas in each unit (rest home, hospital, and dementia unit). Each unit has a smaller quiet lounge for visitors or activities. There are seating alcoves throughout the facility. The communal areas are easily and safely accessible for residents.</p> |

| | | |
|--|----|--|
| activity, and dining needs. | | |
| <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 linen and personal clothing is outsourced. The laundry area is spacious, with one commercial washing machine and dryer, as the cleaning/laundry person launders delicate items and woollens. The laundry has entry and exit doors located near the delivery entrance. There is a defined clean/dirty area in the laundry. There are two dedicated cleaning/laundry persons on duty each day.</p> <p>They have access to a range of chemicals through a mixing system, cleaning equipment and protective clothing. Safety datasheets and product information is available. Cleaning trolleys are kept in locked areas when not in use.</p> <p>Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility and 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. All registered nurses are first aid trained. The facility has a fire evacuation plan that has been approved by the fire service (letter from Fire Service dated 20 March 2017 sighted). A fire drill was provided as part of induction and December 2017 (six monthly).</p> <p>Smoke alarms, sprinkler system and exit signs are in place. A gas barbeque and torches are available in the event of a power failure. Emergency lighting is in place. A civil defence kit is in place and stored in an accessible area. Four thousand litres of stored water is available in tanks. Electronic call bells were evident in resident's rooms, lounge areas and toilets/bathrooms. There are security policies around locking of the facility 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> | FA | <p>General living areas and all resident rooms are appropriately heated and ventilated. Heat pumps are used in communal areas. Resident rooms have individual heat pump/air conditioning units. All rooms have external windows that open allowing plenty of natural sunlight.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed</p> | FA | <p>Radius Glaisdale has implemented the Radius infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPIs. One of the two</p> |

| | | |
|---|----|--|
| <p>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>clinical team leaders (RN) is the designated infection control nurse with support from the facility and clinical managers and DHB infection control service. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Radius infection control programme is reviewed annually at organisational level.</p> <p>Radius has supported the local Covid-19 pandemic response. There are pandemic folders with plans on site, including rapid response plans. Examples of implementation of plans includes additional training for staff around personal protective equipment (PPE) and infection control practices, daily monitoring of residents' temperature while at Covid-19 level 3 and 4, room isolation with staff wearing full PPE when residents have had respiratory symptoms, admission protocols in place for any admissions, and regular (daily and later weekly) zoom meetings with senior staff at support office to distribute information and to gain information continued post level 4 and 3 lockdowns. There is at least two weeks' worth of PPE stocks including masks, gowns, goggles, hand sanitisers, gloves, and hazard bags, with this monitored by the CM. Radius also has an extra supply of stock at head office that can be mobilised on short notice.</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>The clinical team leader (registered nurse) is the infection control (IC) coordinator and is aware of the need to analyse data and the reasons behind this. The IC nurse receives ongoing education including DHB training in October 2020. The IC coordinator is supported by the facility and clinical managers, the GP, the DHB resource person or IC coordinators at other facilities if required.</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</p> | FA | <p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training, and education of staff. The infection control policies link to other documentation and uses references where appropriate.</p> <p>Infection control policies are reviewed as part of the policy review process by Radius. Input is sought from facilities when reviewing policies. The managers receive notification of any new or reviewed policy or procedure and there is evidence of rollout to staff.</p> |

| | | |
|---|----|---|
| appropriate/suitable for the type of service provided. | | |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | <p>The IC nurse ensures training is provided to staff through orientation and additional training. Informal education is also provided (eg, through the toolbox training sessions). The healthcare assistants interviewed stated that they received 'excellent' training that supported them to care for residents. The training is also linked into quality initiatives (eg, a current ongoing corrective action plan looking at reducing the number of urinary tract infections) and includes additional training focused on the early detection and management of UTIs and hand hygiene as a key part of cares.</p> <p>The orientation package includes specific training around hand washing and standard precautions. Hand hygiene is an annual competency (viewed on staff files).</p> <p>Resident education is expected to occur as part of providing daily cares. Staff were observed reminding residents to wash hands and to use sanitiser.</p> <p>PPE education for staff about donning and doffing in preparation for lockdown during pandemic for Covid-19 has occurred initially in March/ April 2020. This is now ongoing during staff meetings and handover especially in relation to Covid-19 and the prevention of an outbreak. Education for visitors has been provided around the use of PPE and any visitor is required to sign in and have their temperature recorded on entry.</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> | FA | <p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme. The service submits data monthly to Radius head office where benchmarking is completed.</p> <p>Infections are collated monthly, including urinary tract, upper respiratory and skin. This data is analysed for trends and the raw clinical indicator data is reported to the quality, RN, and staff meetings.</p> <p>There have been no outbreaks since the previous audit.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked.</p> <p>There is a regional restraint group at the organisational level and a restraint group at the facility, where restraint is reviewed.</p> <p>There were no residents with enablers during the audit and two residents using restraint (bed rail) at the</p> |

| | | |
|---|----|---|
| | | time of the audit. Training around restraint minimisation, enablers and challenging behaviour has been provided as part of the orientation for all new staff. |
| <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 | The clinical manager is the restraint coordinator with a defined job description. Restraint discussion and quality data around restraint and enabler use is included in the quality/risk meetings and clinical meetings. Care staff receive education on safe restraint use at orientation and annually. There is ongoing education including challenging behaviours. Staff complete restraint competencies annually. |
| <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 | A restraint assessment tool is completed for residents requiring an approved restraint for safety. The clinical manager in partnership with the GP, the resident and their family undertakes assessments. Restraint assessments are based on information in the care plan, family discussions and observations. Ongoing consultation with the family are evident. A restraint assessment form had been completed for two resident files reviewed requiring restraint (sighted). Assessments identify risks related to the use of restraint and the specific interventions or strategies to try (as appropriate) before implementing restraint. |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p> | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraint use, risks, and cares to be carried out during the restraint episode are included in the two care plans reviewed. Individual restraint monitoring booklets evidence checks, and cares have been carried out according to the documented frequency described in the resident care plan and monitoring tool. There is an up-to-date restraint register. |
| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes</p> | FA | The restraint evaluations occur three monthly by the clinical manager with family and GP input and then six-monthly as part of the ongoing review as part of their care plan review. Families (where possible) and |

| | | |
|--|----|---|
| of restraint. | | the GP and RNs are included as part of this review. Their engagement in the review process is documented. This was also confirmed with the GP interviewed and one relative whose family member used a bed rail. |
| Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraint usage is monitored monthly. The review of restraint use is discussed at the quality meetings and relevant facility meetings. The facility is proactive in minimising restraint. Internal restraint audits are completed three and six-monthly and demonstrate compliance of the standard. |

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, 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.