

Radius Residential Care Limited - Radius St Helena's 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 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 St Helena's Care Centre

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 20 May 2021 End date: 21 May 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: 47

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 St Helena's is owned and operated by Radius Residential Care Limited. The service provides cares for up to 53 residents requiring rest home and hospital (medical and geriatric) level care. On the day of the audit, there were 47 residents.

This certification audit was conducted against the relevant Health and Disability Services 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 general practitioner.

The service is managed by the facility manager who has been in her role for three years. The clinical nurse manager has also been in her role for three years. Both have previous experience in aged care management and are registered nurses. They are supported by the Radius regional manager, a team of registered nurses and healthcare assistants. Residents, relatives, and the GP interviewed spoke positively about the service provided.

Since the previous audit, the service continues to build good relationships with the wider allied health team including the hospice service. St Helena's staff continue to provide a resident centred approach, and care plan goals and interventions reflect this. The service are implementing electronic systems to improve quality data collation. Residents and relatives commented positively on the homely environment of the facility.

This audit has identified shortfalls around contractor inductions and restraint documentation.

Consumer rights

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

Standards applicable to this service fully attained.

Policies and procedures adhere with the requirements of the Health and Disability Commissioner's 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. 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 can visit residents at times that meet their needs. Examples of good practice were provided. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

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

Some standards applicable to this service partially attained and of low risk.

Services are planned, coordinated and are appropriate to the needs of the residents. A facility manager and clinical nurse manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded. Corrective actions are implemented and evaluated where opportunities for

improvements are identified. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training are embedded, which includes in-service education and competency assessments. Registered nursing cover is provided 24 hours a day, 7 days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

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

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

The activities coordinator implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are provided by an external contractor. A current food control plan is in place. The menu has been approved by a dietitian. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were satisfied with the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standards applicable to this service fully attained.

The building has a current warrant of fitness. Preventative and reactive maintenance schedules are maintained. Chemicals are stored safely throughout the facility. Cleaning and laundry staff are providing appropriate services. All bedrooms are single occupancy. There is sufficient space to allow the movement of residents around the facility using mobility aids. There is one large main open plan lounge and dining area, and one TV lounge. There are small seating areas around the facility for residents and relatives to enjoy. The outdoor areas are safe, well maintained, easily accessible and provide seating and shade. The internal areas are ventilated and heated appropriately. There is an approved evacuation scheme and emergency supplies are available. There is a minimum of one first aid trained staff member on every shift.

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.

Some standards applicable to this service partially attained and of low risk.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enabler. During the audit, there was one resident using restraints and no residents were using an enabler. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

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

Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidenced 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. There has been one outbreak since the previous audit which was well managed, logs were maintained, and appropriate notifications were made.

The facility has responded promptly and appropriately to the Covid-19 pandemic, policies, procedures and the pandemic plan have been updated to include Covid-19. Resource information is easily accessible for registered nurses if lockdown levels change after hours. Adequate supplies of personal protective equipment were sighted during the audit.

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	48	0	2	0	0	0
Criteria	0	99	0	2	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 St Helena's 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 annual in-service programme. Interviews with managers (facility manager, clinical nurse manager) and eleven staff (three healthcare assistants (HCAs), two registered nurses, two housekeeping, two kitchen assistants, one maintenance, one activities coordinator) confirmed their understanding of the Code and its application to their job role and responsibilities. Five residents (two rest home including one resident who identifies as Māori, and three hospital), and four relatives (one rest home, three hospital) interviewed, confirmed that staff respect the need for resident privacy and support residents in making choices.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information	FA	There are policies documented around informed consent and resuscitation. Informed consent processes are discussed with residents and relatives on admission. Written consents are signed by the resident or their enduring power of attorney (EPOA). Consents sighted included (but are not limited to), general consents, transfer of medical records, consent for treatment and consent for the influenza vaccine. Consents were scanned onto the system with the admission risk assessments. Advanced directives are signed for separately. There was evidence of discussion with relatives when the general practitioner

they need to make informed choices and give informed consent.		<p>completed a clinically indicated not for resuscitation order. The electronic resident files reviewed had informed consent and admission agreements signed and scanned into the electronic system.</p> <p>Healthcare assistants and registered nurses interviewed confirmed that verbal consent is obtained when delivering care. Discussion with relatives identified that the service actively involves them in decisions that affect their relative's lives.</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 resident files include information on residents' family/whānau and chosen social networks. The HCAs and activities staff interviewed all commented that they advocate on behalf of the residents.</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 outside of the facility. Residents are supported and encouraged to remain as involved in the community as they are willing and able to do. Examples provided included attending the RSA and church services. Relatives and friends are encouraged to be involved with the service and care. Key people involved in the resident's life are documented in the care plans.</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. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed described the process around reporting complaints.</p> <p>A complaints' register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner; meeting requirements determined by the HDC. Only one complaint, lodged by the DHB, was received in 2020 with a significant number of corrective actions implemented around documentation and education and training for end-of-life care. These corrective actions have been signed off as implemented. In 2021, one complaint lodged with the provider in March included acknowledgement, an investigation and a meeting with the complainant to discuss the outcome of the complaint. This complaint was not resolved and has been escalated by the family to HDC (received 5 May 2021). At the time of the audit, the facility manager was gathering the required information to submit to</p>

		<p>HDC by 27 May 2021.</p> <p>There is evidence of lodged complaints being discussed in the quality, RN and staff meetings.</p>
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	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. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code (in English and te reo Māori) are displayed. The facility manager or clinical nurse manager discusses information in the pack with residents/relatives on admission. 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>
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>A tour of the premises confirmed there are 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. Staff interviewed could describe definitions around abuse and neglect. An annual resident satisfaction survey was last completed in October 2020 and the results indicated that most respondents reported the overall resident experience as being good or very good. Residents and relatives interviewed confirmed that staff treat residents with respect. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents interviewed confirmed their values and beliefs are considered. Interviews with HCAs described how choice is incorporated into resident cares.</p>
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	<p>The Māori health plan for the organisation references local Māori health care providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Māori consultation is available through the documented iwi links and Māori staff. During the audit, there were two residents that identified as Māori. One Māori resident file reviewed confirmed that Māori cultural values and beliefs are addressed in the Māori health care plan. This includes their tribal affiliations, and care plan strategies that link to spiritual wellbeing (te taha wairua), mental wellbeing (te taha hinengaro) and physical wellbeing (te taha tinana) where identified. Residents are also assessed regarding tikanga for body parts, suggestions for de-escalation if required, restraint procedures and any special instructions regarding taonga. One resident who identified as Māori was interviewed and confirmed that their values and beliefs are being met by the service.</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>An initial care planning meeting is carried out where the resident and/or whānau as appropriate, are invited to be involved. Individual beliefs and/or values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs.</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>Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. The facility manager provided guidelines and examples of performance management for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Policies and procedures align with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. An annual in-service training programme is implemented as per the training plan. Three-hour blocks of time are allocated a minimum of twice per year for education and training. Additional toolbox talks and annual staff competencies (e.g., manual handling, medication, syringe driver, first aid) complement the education programme.</p> <p>A quality improvement initiative plan has been implemented addressing end of life care. A range of educational topics addressing this topic have been presented to staff including (but not limited to) palliative care for older people with dementia, caring for ourselves, spiritual care, and the physiology of dying. Three staff completed an educational programme delivered by hospice (10 modules) in 2020 with another group of staff are scheduled to begin their end-of-life training through hospice in 2021. An interview with an external palliative care specialist confirmed that the staff are doing a very good job caring for palliative residents.</p> <p>Outcomes for the service are monitored with benchmarking across all Radius facilities. Feedback is provided to staff via the various meetings and through graphs and notices on the noticeboard in the staffroom. There is a minimum of one RN on site 24 hours a day, seven days a week. A physiotherapist is available two hours a week. Registered nurses and HCAs were described by residents and family as being caring. A GP visits the facility two days a week.</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>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 system. All incident reports reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. One Russian speaking resident has translation cards in her room to assist staff. In addition, family members assist with translation.</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>	FA	<p>Radius St Helena's is part of the Radius Residential Care group. The service provides rest home, and hospital (geriatric and medical) levels of care for up to 53 residents. There were 47 residents (27 rest home and 20 hospital level) at the facility during this full certification audit. All beds are certified as dual purpose. One resident (hospital level) was on an end-of-life contract, and three residents (one hospital and two rest home) were on a long-term service – chronic health conditions contract (LTS-CHC). The remaining residents were on the age-related residential care contract (ARRC).</p> <p>There is a site-specific business plan 1 April 2020 to 31 March 2021 that has been reviewed and links to the Radius Residential Care group strategies and business plan targets. An organisational chart is in place. Monthly reviews are undertaken to report on achievements towards meeting business goals including meeting defined quality targets.</p> <p>The facility manager (registered nurse) has been in the role since July 2018 and previously was the clinical nurse manager. She has worked for Radius for eight years. She is supported by a clinical nurse manager who has been in the role for three years. The regional manager (also a registered nurse) was present during the days of the audit and oversees the operations of five Radius South Island locations including St Helena's. She has been in her role since November 2020.</p> <p>The facility manager and clinical nurse manager have maintained at least eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe</p>	FA	<p>The clinical nurse manager covers during the temporary absence of the facility manager. The regional manager is also available for support.</p>

services to consumers.		
<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>	PA Low	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the facility manager, clinical nurse manager and staff reflected staff involvement in quality and risk management processes. Resident meetings are scheduled monthly, led by the facility manager. Minutes are maintained.</p> <p>The 2020 annual resident surveys (45% return rate with 23 of 52 surveys returned) reflect satisfied residents, in particular around the care provided, feeling welcome, and laundry services; 94% would recommend the facility to others. A food satisfaction survey was completed in April 2021. Results were discussed with residents in the resident meeting. Corrective actions being implemented include ordering a hot box so that food stays warm and offering residents two meal choices at tea time. Interviews with residents confirmed that they are very pleased with the actions taken.</p> <p>The service has policies and procedures and associated implementation systems to provide an appropriate level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality monitoring programme is designed to monitor contractual, standards compliance and service delivery. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data (e.g., falls, infections, restraint use, physical aggression, medication errors, unintentional weight loss) which are utilised for service improvements.</p> <p>An internal audit programme is implemented. Internal audits are completed as per the schedule. Corrective actions are required for results that reflect less than 95% compliance. The audit is then repeated after eight weeks. A corrective action plan register is being implemented. Four corrective actions documented in 2020 (norovirus outbreak, medication incidents, reduce infections, gap in care plan/interRAI reviews) reflected evidence of interventions, discussions, target date for completion, evidence to support progress is achieved and sustained, and evidence of sign off. Quality results are communicated to staff across a range of meetings (monthly staff meetings, monthly quality/health and safety meetings, monthly RN meetings) and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are established by head office. The health and safety officer (maintenance officer) interviewed confirmed his understanding of health and safety processes. The officer and health and safety representatives have completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. Missing was evidence that external contractors are orientated to health and safety processes.</p> <p>Falls prevention strategies are in place including: intentional rounding; sensor mats; post falls reviews; and individual interventions.</p>

Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	<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 for each incident/accident with immediate action noted and any follow-up action required. A review of 10 incident/accident forms (unwitnessed falls, pressure injury, skin tear, bruising, medication errors) identified that forms are fully completed and include follow-up by a RN. Neurological observations are carried out for any suspected injury to the head, including unwitnessed falls.</p> <p>The facility manager can identify situations that would be reported to statutory authorities including (but not limited to) pressure injuries (grade three or higher), one missing resident and one outbreak (January 2020). The outbreak was also communicated to public health authorities.</p>
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	<p>Human resources policies cover recruitment, selection, orientation, and staff training and development. Seven staff files reviewed (two RNs, four HCAs, one cleaner) provided evidence of reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals for staff employed for over one year. A register of RN staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. The orientation programme has recently been enhanced. Interviews with staff confirmed that they were given adequate time to orientate to the service.</p> <p>There is an implemented annual education and training plan that exceeds eight hours annually. In-service training is broken down into three-hour blocks of time. Staff commented that this has been positively received.</p> <p>There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. Seven of nine RNs (including the facility manager and clinical nurse manager) have completed their interRAI training. Twenty-five HCAs are employed. Seven HCAs have completed a level four Careerforce qualification (or its equivalent), five have completed a level three certificate and two have completed a level two certificate. Staff are required to compete written core competencies that are applicable to their job role and responsibilities. Completion of competencies begins during the new staff's orientation and continues annually.</p>
Standard 1.2.8: Service Provider Availability	FA	A policy is in place for determining staffing levels and skills mix for safe service delivery. Residents and family members interviewed reported there are sufficient staff on duty. There is a full-time facility

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>manager/RN and clinical nurse manager/RN who work from Monday to Friday and provide on-call cover. There were 27 rest home and 20 hospital level residents at the time of the audit. One staff RN is rostered on the AM, PM and night shifts. RNs are supported by six HCAs on the AM shift (four eight hour (long) shifts and two short shifts (0700 – 1330). The PM shift is staffed with five HCAs (two long and three short (1500 – 2200, 1500 – 2130, and 1600 – 2200). The night shift is staffed with two HCAs. Activities staff cover five days a week. They provide HCAs with ideas for activities over the weekends. There are designated cleaning staff seven days a week.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are held in an electronic format and are protected from unauthorised access.</p>
<p>Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The resident files reviewed evidenced assessment prior to entry by the needs assessment service coordination team (NASC). The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All admission agreements sighted were signed and dated either by the resident or the EPOA on admission to the service. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager or the clinical nurse manager. The service has an information pack available for residents/families at entry which includes information about services provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or</p>	FA	<p>There are documented policies to guide staff around guidelines for death, discharge, transfer, documentation, and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service using the electronic transfer form. The facility uses the yellow envelope transfer system. One resident file reviewed evidenced a transfer to hospital. Progress notes evidenced the process, including discussion with the afterhours service, arranging the ambulance, notifying the residents family, and preparing the appropriate</p>

transfer from services.		documentation. A verbal handover was provided.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	<p>The medication management policies and procedures comply with medication legislation and guidelines. Registered nurses are responsible for the administration of medications and they complete an annual medication competency and attend medication education annually. Registered nurses have completed syringe driver competencies. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication fridge temperatures and medication room temperatures are recorded and within expected ranges.</p> <p>The night registered nurse reconciles medications delivered from the pharmacy. The service uses four weekly blister packs for regular and 'as required' medications. Radius St Helena's utilise paper-based medication charts. All 14 paper-based medication charts reviewed had photo identification, allergy status identified. The medication charts reviewed were legible, medications were prescribed appropriately, and evidenced at least three-monthly reviews signed by the GP. Medication prescribed is signed as administered on the signing chart. There were one rest home and two hospital residents self-medication inhalers on the day of audit. Competencies were in place and reviewed by the GP three monthly. Standing orders are not used.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	<p>There is a fully functional kitchen. The food service is contracted, and all meals are prepared and cooked at another Radius facility located nearby. The kitchen assistant is responsible for the daily meal service. Food services staff have completed food safety training and chemical safety training. The summer and winter menus have been reviewed by a dietitian, and a current food control plan is in place. The food is transported in hot boxes to the facility kitchen, where food is served from a bain marie to the residents in the dining room adjacent to the kitchen. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff who record appropriate information and forward the form to the contracted service. Resident dislikes are known and accommodated, there are two options for lunch and tea meals, the kitchen assistants collect residents 'orders' and send to the contracted service. Special diets accommodated include gluten free, dairy free, diabetic desserts and modified/pureed diets. Meals observed on the day of audit were well presented including pureed meals. Both kitchen assistants interviewed were knowledgeable around residents' preferences and dietary requirements.</p> <p>The temperatures of refrigerators, freezers, end-cooked foods and serving temperatures are monitored and recorded daily. All food is stored appropriately and dated. Chemicals are stored in a locked cupboard. A cleaning schedule is maintained.</p> <p>Residents and the relatives interviewed were satisfied with the quality and variety of food served.</p>

Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reason for declining service entry to prospective residents should this occur and communicates this to prospective residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	There is a suite of assessments available on the resident's electronic system. The resident files reviewed indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Risk assessments on admission included (but not limited to); pain, activities of daily living (ADL) falls, and pressure. Other risk assessments were completed as appropriate. InterRAI assessments had been completed for long-term residents and informed the long-term care plans. Goals were identified through the assessment process and linked to care plan interventions.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long-term care plans reviewed were resident centred. Interventions documented support needs and provided detail to guide care (link 2.2.2.1). There was evidence of service integration with documented input from a range of specialist care professionals including the wound care specialist, dietitian, physiotherapist, occupational therapist and mental health team including the psychogeriatrician. Care plan interventions included strategies and interventions as advised by the specialists. Short-term care plans were in use for acute changes in health status, these are reviewed and updated or included in long term interventions as appropriate. Residents and relatives interviewed stated that they were involved in the care planning process. The healthcare assistants interviewed advised that the care plans were easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate	FA	When a resident's condition changes the RN initiates a GP consultation. The registered nurses interviewed stated that they notify relatives about any changes in their relative's health status. The care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care

<p>and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>plans being updated as residents' needs changed.</p> <p>Healthcare assistants interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management plans and wound evaluation electronic forms are in place for all wounds. Wound monitoring occurs as planned. There are currently 22 wounds (including four residents with more than one wound) wounds include skin tears, abrasions, incontinence dermatitis, surgical wounds, and chronic ulcers.</p> <p>There were two stage 1 pressure injuries, one stage 2 and one stage 4 pressure injuries on the day of the audit. Incident reports were completed for the pressure injuries and a section 31 notification had been completed for the stage 4 pressure injury. There has been GP and wound care nurse specialist input for the chronic wounds. Photos have been taken at regular intervals to evidence progression or deterioration towards healing.</p> <p>A suite of electronic monitoring forms is available for registered nurses to utilise. Monitoring forms sighted included (but not limited to); weight, vital signs, position changes, neurological observations, intentional rounding (safety checks), and wounds.</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>An activities coordinator coordinates the activities programme for all residents. Activities run from 9 am to 4 pm Monday to Friday. The activity planner for the following month is discussed at the residents' meetings and ideas and suggestions for residents are included in the next planner.</p> <p>Each resident has an individual activities assessment (about me) on admission. Based on this information, an individual activities (leisure) plan is developed as part of the care plan by the registered nurses with input from the activities staff. The activities coordinator is responsible for the pastoral care plan and interventions. Resident participation in activities is documented on the attendance register, then transferred to the resident's individual daily log in the electronic resident file. The residents' files sampled included activities plans within the care plans that are evaluated at least six-monthly when the care plans are evaluated. The activities coordinator documents a progress note of attendance.</p> <p>All residents are free to choose whether they wish to participate in the group activities programme or their individual plan. Significant time is dedicated to one-on-one activities including (but not limited to): reminiscence, chats, hand massages, and nail care. Group activities include quizzes and delivery of meals on wheels for the red cross, balloon games, baking, crafts, board games, and housie. There are regular shopping trips and outings to places of interest. Celebrations such as resident birthdays, Mother's Day, Father's Day, Melbourne cup and St Patricks day are celebrated.</p> <p>Resident meetings are held monthly, meeting minutes evidenced the residents having the opportunity to</p>

		<p>provide input into the activities plan.</p> <p>Residents are supported to be independent, accessing community groups, and shopping trips as they choose. Church services are included in the activity planner. Residents and relatives interviewed commented positively on the activity programme.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	<p>Four of the long-term care-plans reviewed had been evaluated by the registered nurse six-monthly or when changes to care occurred (three residents had not been admitted within the last six months). Any updates required to care plan interventions following the care plan evaluation in case conference is updated in the care plan four weeks post admission and then six-monthly. The case conference documented relatives' involvement in care plan reviews. Care plans were signed electronically either by the resident or enduring power of attorney. Leisure (activity) plans are in place for each of the residents and these are also evaluated six-monthly. There is at least a three-monthly review by the GP. The relatives interviewed confirmed that they are informed of any changes to the care plan. The resident on the EOL contract care plan has been reviewed to reflect their current level of independence.</p>
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	<p>Radius St Helena's facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals via the clinical manager to nurse specialists and allied health services. Referrals to medical specialists are made by the GPs. Referrals and options for care were discussed with the relatives/NOK as evidenced in interviews, progress notes and medical notes. The staff provided examples of where a resident's condition had changed, the resident level of care was reassessed. Examples of close liaison with dietitians, physiotherapist, mental health services, hospice and wound care specialists were sighted in resident files reviewed.</p>
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous	FA	<p>There are implemented policies in place to guide staff in waste management. Healthcare assistants, kitchen staff and housekeeping 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. Chemicals sighted were labelled correctly and were stored safely throughout the facility, housekeeping trolleys are lockable. Safety datasheets are available. The one sluice room have personal protective clothing readily available.</p>

substances, generated during service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>The building has a current building warrant of fitness. There is a main open plan dining and lounge area, and a second TV lounge. There are small seating areas for residents to enjoy. The building is all on one level and all areas are easily accessible to residents using mobility aids.</p> <p>There is a fulltime maintenance person employed to address the reactive and planned maintenance programme, who could easily describe the maintenance programme and regular checks performed. All medical and electrical equipment was recently serviced and/or calibrated. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. External contractors are available across seven days if required.</p> <p>The facility has sufficient space for residents to mobilise using mobility equipment. Residents interviewed enjoyed the environment, relatives commented on the homeliness of the facility.</p> <p>There is a gazebo in the central courtyard off of the lounge/ dining area which provides seating and shade, all areas are easily accessible for residents using mobility aids. The gardens are well maintained.</p>
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All rooms at St Helena's have ensuite facilities large enough to cater for resident's needs and equipment. Toilets and showers have privacy systems in place identified by red/green identifiers. Communal resident and visitor toilet facilities are available close to communal areas. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed	FA	<p>There is one double room, which is only used for married couples or single occupancy. This room was vacant on the day of the audit. All other resident rooms are single.</p> <p>There is sufficient space for the safe use and manoeuvring of mobility aids, including those required by hospital level care residents. Residents are encouraged to personalise their bedrooms as viewed on the</p>

areas appropriate to the consumer group and setting.		day of audit.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The main lounge/dining space is centrally located next to the kitchen. The area is spacious and light and has access to two internal courtyards with seating and shade provided. There is a second TV lounge which is also light and sunny. Both areas were well utilised by residents. There were other small seating areas around the facility for residents to enjoy. The flower gardens and grounds around the facility are well maintained. All indoor and outdoor communal areas are easily accessible to residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The facility is cleaned by dedicated housekeeping staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme and through the chemical provider who visits monthly. Cleaning trolleys are lockable and are stored in locked areas when not in use. The housekeepers interviewed were knowledgeable around infection control practices and have maintained cleaning of high touch areas. All laundry is laundered off site at a commercial laundry. There is laundry pick-up and delivery five days per week (Monday to Friday) and more often if required. There was an adequate supply of linen sited in storage areas on the day of audit. There is a laundry with defined clean and dirty areas of the laundry. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility and the laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is a comprehensive emergency management plan to guide staff in managing emergencies and disasters. There is a minimum of one first aid trained staff member on every shift. The facility has an approved fire evacuation plan. Fire evacuation drills take place every six months with the last drill occurring on 16 February 2021. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and ongoing training. Two civil defence kits are checked a minimum of annually with one kit stored in the outdoor shed and the other kit stored at the nursing station. There is sufficient water stored for three litres per day for three days per resident with 20 litres stored in each resident room and additional stores (5000 litres) in the ceiling space. There are alternative cooking facilities available with a gas barbecue. Electronic call bells were evident in resident's rooms, lounge areas and toilets/bathrooms. Call bells are

		checked monthly. The facility is locked before nightfall with alarms on all five access doors. All windows include security latches.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	General living areas and all resident rooms are appropriately heated and ventilated. There are heat pump/air conditioning units in corridors and lounges. Resident rooms are individually heated by wall panel heaters. All rooms have external windows that open allowing plenty of natural sunlight. Residents and relatives interviewed reported the facility was maintained at a comfortable temperature. The maintenance person completes air temperature audits.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Radius St Helena's has an established infection control programme which is developed by the organisation and is reviewed annually. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the designated infection control nurse with support from the clinical manager. Infection control data is discussed as an agenda item at facility and staff meetings. Visitors are asked not to visit if they are unwell. There are hand sanitisers appropriately placed throughout the facility. Outbreak kits are readily available. All visitors to the facility complete a wellness declaration including temperature checks and contact tracing on entry to the facility in line with current Covid-19 guidelines.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	A registered nurse is the designated infection control (IC) coordinator (currently on leave). Infection control was being overseen by the clinical manager at the time of the audit. The clinical manager has attended infection control education in 2020 and attends study days related to infection control through the DHB when available. There are adequate resources to implement the infection control programme. The infection control coordinator has good external support from the local laboratory, IC nurse specialist at the DHB, the organisational infection control nurse, the public health team and the GP. There are regular housekeeping and laundry internal audits performed. All staff interviewed were well versed on day-to-day infection control practices, and isolation procedures. The service has managed the current Covid-19 pandemic well. There has been ongoing information to all staff around how to manage any case of Covid-19 should there be one and process put in place as per policy. This has included instructions around visiting at each level, management of staff and use of personal protective equipment (PPE). There is sufficient PPE on site to manage should this be required for

		an outbreak including a case of Covid-19 for at least two weeks should this be required. There were frequent zoom meetings with head office during the lockdown periods. Emails and correspondence were maintained with relatives throughout the lockdown periods. Contact was maintained between relatives and residents via phone calls and video calls via appointment.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are organisational infection control policies and procedures appropriate for the size and complexity of the service. The policies were developed by the Radius clinical management team and have been reviewed and updated to include Covid-19 policies. The pandemic plan has been updated in line with Covid-19 guidelines. 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.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	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 annually. A practical hand washing competency is completed on orientation and annually. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. Education was provided around donning and doffing PPE, handwashing and the use of hand sanitiser, standard precautions and isolation procedures in line with guidelines for Covid-19.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities,	FA	Infection surveillance is an integral part of the infection control programme and is described in Radius' infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual electronic resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Infection worklogs are generated through the electronic resident database. Surveillance of all infections is entered on to a monthly infection

<p>and methods that have been specified in the infection control programme.</p>		<p>register. This data is monitored and evaluated monthly and annually and provided to Radius head office. Infections are part of the key performance indicators (KPI) and benchmarked within the organisation. Quality improvements are raised for any infection rates above the KPI.</p> <p>There has been one norovirus outbreak since the previous audit. Infection logs were maintained to include all staff and residents affected. There were daily meetings, and the outbreak was discussed with staff at handovers. Relatives were updated of visiting requirements. Notifications were made in a timely manner and the public health team were updated daily until symptoms had cleared.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>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 no residents using enablers and one hospital level resident using two restraints during the audit. This resident file was 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 (clinical nurse manager) 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,</p>	PA Low	<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>

in relation to use of restraint.		The file of one resident using two restraints (bedrails and chair harness) was reviewed. The assessment was detailed regarding the use of bedrails but was missing relevant and specific information in relation to the chair harness being used.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	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 although was missing for the resident using the chair harness (link 2.2.2.1). An internal restraint audit, conducted six-monthly, 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 two hourly checks were sighted for the resident using the bedrails and chair harness restraints.</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>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly and include family, evidenced in the resident file where restraints were in use. Restraint use is also discussed monthly in the quality/health and safety, staff and RN meetings, confirmed in the meeting minutes. There have been no adverse events relating to restraint use reported since the last audit.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	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.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.	PA Low	A health and safety programme is established. Staff begin their health and safety training during their orientation. This continues annually. The external contractors/service providers health and safety agreement is a written declaration signed by the contractor to confirm that the contractor has their own health and safety policies; and the tradesperson has a current practising certificate and indemnity insurance. Missing was evidence to confirm that	The external contractors/service providers health and safety agreement and evidence of completing a health and safety orientation has not been implemented.	Ensure that there is documented evidence of external contractors signing a health and safety agreement and completing health and safety orientation, in line with Radius policy.

		this agreement has been implemented. Also missing was evidence that the contractor was orientated to the facility's health and safety processes.		90 days
Criterion 2.2.2.1 In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies.	PA Low	One resident was using two restraints (bedrails and chair harness). The assessment for the use of bedrails was comprehensive and including potential risks. This assessment was linked to the resident's care plan. Missing was specific information in relation to the chair harness restraint to assist in guiding staff.	The chair harness restraint used for one resident was assessed as a specialty chair and did not indicate the type of restraint, and risks associated with this restraint. This information was also missing in the resident's care plan.	Ensure the chair harness restraint is assessed in a comprehensive manner including identifying any risks associated with the use of this restraint, and that these risks are carried over to the resident's care plan. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.