

Radius Residential Care Limited - Radius Windsor Court Rest Home

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 Windsor Court Rest Home
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: 28 July 2021 End date: 29 July 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:	64

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Radius Windsor Court is owned and operated by Radius Residential Care Limited. The service provides care for up to 76 residents requiring rest home, hospital or dementia level care. On the day of the audit, there were 64 residents. Currently there is an acting facility manager (regional manager) who is supported by an experienced clinical nurse manager. A Radius regional manager and a clinical nurse leader support the management team.

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 resident's and staff files, observations and interviews with residents, relatives, staff, management and the nurse practitioner.

The residents, relatives and general practitioner spoke positively of the care and service provided at Radius Windsor Court.

This audit has identified an area for improvement around interventions.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. In addition to a Māori health plan for the organisation, there is a Māori care plan in place for each resident who identifies as Māori.

Discussions with residents and relatives confirmed that residents, and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided and observed during the audit.

There is an implemented system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner. Complaints received are managed in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and are appropriate to the needs of the residents. An acting 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 are embedded into practice. Corrective action plans 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, specific to the role that they are undertaking.

Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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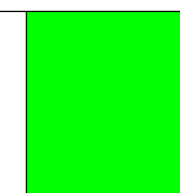
There is welcome pack for potential residents and family members. The registered nurses' complete assessments, care plans and evaluations using the eCase electronic system. Residents/relatives are involved in planning and evaluating care. Service delivery plans demonstrate service integration and allied health professionals involved in the care of residents. Care plans are evaluated six monthly or more frequently when clinically indicated.

The activities team provide an activities programme that meets the physical and cognitive abilities of the residents. The programme includes outings, volunteers and community visitors. Each resident has an individualised plan.

The medication management system follows recognised standards and guidelines for safe medicine management practice. Staff complete competency assessments. The general practitioner/nurse practitioner reviews medication charts at least three-monthly.

Meals are prepared on site. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours. Residents interviewed responded favourably regarding the food that was provided.

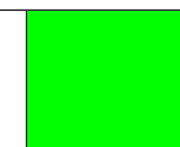
Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness. There is a reactive and planned maintenance system in place. Chemicals are stored safely throughout the facility. There is a mix of ensuite, single or shared and communal toilets/showers. Internal communal lounges and dining rooms are easily accessible. External areas are safe and well maintained with shade and seating available. The dementia unit's outdoor garden and walking pathway is safely fenced. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services. There is a qualified first aider on each shift.

Systems and supplies are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The facility has a restraint free philosophy. If restraint is used, it is a last resort. The restraint coordinator/clinical nurse manager is responsible for ensuring restraint minimisation policies and procedures are adhered to, and for providing restraint minimisation education for staff. There were three residents voluntarily using enablers and no residents using restraint at the time of the 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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical nurse manager is the infection control coordinator who is responsible for the collation of infections, orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility.

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	44	0	0	1	0	0
Criteria	0	92	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Radius Windsor Court policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner's (HDC) 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 fourteen staff (six healthcare assistants [HCAs] who work during the AM and PM shifts in the rest home/hospital wings and dementia wing), two registered nurses (RNs), two activities coordinators, two maintenance staff, one housekeeping/laundry staff, one kitchen manager) confirmed their understanding of the Code and could describe its application to their job role and responsibilities. Six residents (five rest home and one hospital) and four relatives (one rest home, one hospital and two dementia) interviewed confirmed that staff respect their 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	FA	Eight resident files were reviewed, (three rest home including one respite care, three hospital level and two dementia care including one resident under long-term chronic health condition – LTS-CHC). Informed consent processes had been discussed with residents (as appropriate) and families on admission. Written general consents and specific consents (e.g. vaccine consents) were sighted on the electronic files. Advance care plans were available on the electronic resident files. There was evidence of discussion with family when the GP completed a clinically indicated 'not for

<p>information they need to make informed choices and give informed consent.</p>		<p>resuscitation' order where residents were deemed not to be competent. The EPOA had been activated in the files reviewed of the two dementia care residents and in the file of one hospital resident. The registered nurses and healthcare assistants confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents interviewed, confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of complaints process. There are complaint forms available that are visible and located next to a suggestions box. Information about complaints is provided on admission. Staff interviewed understood the process around reporting complaints.</p> <p>There is an electronic complaints' register that is being managed by the (acting) facility manager. Eight complaints were lodged in 2020 and five have been lodged (year-to-date) in 2021. Three complaints have been lodged through HDC in 2021 and one has been lodged through the DHB in 2021. One of the three HDC complaints is closed and three remain under investigation by HDC. One explanation provided during the audit is a fairly recent high RN staff turnover (60% for June 2020 – June 2021) with six RN resignations). As a result of these resignations, a number of recruitment efforts were implemented. The acting facility manager reported that they are currently fully staffed with RNs; however, three additional RNs have been recruited and the acting facility manager is awaiting their work visas.</p> <p>Other corrective actions implemented as a result of the HDC complaints lodged include the following: clinical staff have received additional training around communication with family in relation to acute medical events; clinical staff have received additional training in identifying the signs and symptoms of acute deterioration;</p>

		<p>and clinical staff have received additional training in responding to the unresponsive resident/how to respond in a medical emergency. This training is scheduled to continue in August and November 2021 and January 2022. Other corrective actions implemented have included a restructure of kitchen staff with the employment of a trained chef, and the regular (quarterly) completion of resident satisfaction food surveys to ensure residents are satisfied with their meals.</p> <p>Interviews with residents and families reflected their understanding of the complaints process. They confirmed that any issues identified are addressed, and they feel comfortable to raise any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them explaining the Code. Large print posters of the Code are displayed throughout the facility. Either the facility manager or clinical nurse manager discusses the information 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>
<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>:</p> <p>A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with dignity and respect.</p> <p>The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with HCAs described how choice is incorporated into resident cares.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and</p>	FA	<p>The organisation's Māori health plan references regional Māori health care providers and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. For those residents who identify as Māori, cultural needs are addressed in their resident-specific Māori care plan.</p> <p>At the time of the audit, five residents at the facility identified as Māori. One resident was interviewed who</p>

<p>acknowledges their individual and cultural, values and beliefs.</p>		<p>confirmed that her cultural needs are being met by the service. Links to her whanau were evident in her Māori care plan and were expressed during the interview. Residents who identify as Māori were observed greeting others in Te Reo during the audit. Music playing was another example of a regular cultural event, led by a Māori resident.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Cultural education is an annual topic that staff are required to complete. The 2020 resident satisfaction survey identified that the resident's cultural needs are being met.</p> <p>An initial care planning meeting is carried out where the resident and/or whānau, as appropriate, are invited to be involved. Individual beliefs or values are discussed and incorporated into the resident's care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Families are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.</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>Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. The RNs supervise staff to ensure professional practice is upheld. The abuse and neglect processes cover harassment and exploitation. Residents interviewed stated that the staff treated them with respect.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<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. There is a minimum of two RNs onsite during the morning and afternoon shifts, and one RN is onsite during the night shift. A general practitioner (GP) or nurse practitioner (NP) is onsite three days per week with on-call cover provided 24/7.</p> <p>An annual in-service training programme is implemented as per the training plan. Additional training is provided for the RNs from the DHB. HCAs are encouraged to complete a qualification through the Careerforce programme. Education is provided three different ways; through in-service training, attendance at a scheduled full day training day and reading relevant education materials and completing a competency assessment.</p> <p>A monthly analysis of quality data results (e.g., falls, infections, pressure injuries, complaints received) is reported each month and includes an analysis of this data. Residents' falls are analysed with input provided by a physiotherapist who is available two days a week (16 hours). Staff are kept informed regarding at-risk</p>

		<p>residents through the eCase electronic programme, at staff handovers, and in staff meetings.</p> <p>The latest resident satisfaction survey (June 2020) results indicated that 90% of residents are satisfied or very satisfied with the services they are receiving and would recommend Radius Windsor Court to a family member or friend.</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 15 adverse events reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member and/or if their family member is involved in an adverse event. There is an interpreter policy in place and contact details of interpreters are available. At the time of the audit, there were no residents who were unable to understand English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Radius Windsor Court is a Radius aged care facility located in the rural town of Ohaupo. The facility is certified to provide rest home, hospital (medical and geriatric) and dementia levels of care for up to 76 residents. There are 20 dementia beds in a secure dementia unit. The remaining beds include 8 dedicated rest home beds and 48 dual-purpose (rest home/hospital) beds. On the day of the audit there were 64 residents (28 rest home, 21 hospital, and 15 dementia).</p> <p>The current 2021/2022 annual business plan for Radius Windsor Court links to the organisation's vision and values. Annual goals reflect regular (quarterly) reviews that are forwarded to the regional manager. Results are communicated to staff in the monthly meetings.</p> <p>The acting facility manager is a registered nurse whose original role is the Radius regional manager for this facility. She holds a master's degree in Nursing and has eight years of aged care experience. She has been in an acting role as facility manager at Radius Windsor Court since June 2021. Interviews for a suitable replacement were in process at the time of the audit. Plans are in place to recruit a facility manager who holds a current practising certificate in nursing. The CNM has been in his role for 15 months. He has worked in aged care for 11 years, with 4 of the 11 years as a clinical manager.</p> <p>The acting facility manager and CNM have maintained at least eight hours of professional development activities related to management of an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p>	FA	<p>The CNM or regional manager covers during the absence of the facility manager, which was the situation during this audit with the regional manager working as the acting facility manager until a suitable replacement is found. Additional support is provided by the Radius national quality manager and the Radius eCase</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>coordinator, both who were available during this certification audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>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 managers, including the national quality manager, and staff reflected their involvement in quality and risk management processes.</p> <p>Resident meetings are held three-monthly. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. The last survey was completed in June 2020 (sample size 25 residents and family). Survey results reflect overall satisfaction. Residents feel cared for and were reported as enjoying the laughter and family atmosphere. Corrective action plans were implemented to address two areas of concern (activities programme, food services). Results were communicated to residents and staff, evidenced in the applicable meeting minutes.</p> <p>The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Clinical guidelines are in place to assist care staff.</p> <p>The quality programme is designed to be monitored against contractual and health and disability standards. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Internal audits are being completed as per the internal audit schedule. Corrective actions are implemented where scores reflect opportunities for improvements (below 95% threshold). The internal audit is then repeated every eight weeks, to evidence the effectiveness of the corrective actions implemented, until the internal audit scores 95% or higher. Quality results are communicated to staff across the variety of meetings scheduled. Meeting minutes are retained in the staff room for staff to read and sign if they are unable to attend.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. A health and safety representative who is fairly new to her role was interviewed. She is scheduled to attend external training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Staff training begins during their orientation and continues annually.</p>

		<p>Contractors are orientated to health and safety processes by the maintenance staff.</p> <p>Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions. Physiotherapy input is provided for residents who are at high risk of falling (e.g., two or more falls).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of 15 incident/accident forms (witnessed and unwitnessed falls, pressure injuries, episodes of challenging behaviours) identified that the electronic accident/incident forms are fully completed and include follow-up by a registered nurse. Families/EPOA are kept informed. Missing was consistent evidence of neurological observations being recorded as per Radius protocol for four of eleven unwitnessed falls (link 1.3.6.1). The clinical manager signs off on all adverse events which indicated that the event is closed.</p> <p>The regional manager was able to identify situations that would be reported to statutory authorities including stage three and unstageable pressure injuries, and one police investigation. There has been one gastro-intestinal outbreak since the previous audit with the DHB and public health authorities notified.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (one clinical nurse manager, one staff RN, three HCAs, one cleaner, one kitchen manager and one activities coordinator) included a comprehensive recruitment process which included reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals.</p> <p>A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. Training is provided either as an in-service, attendance at a study day, or if the staff member is unable to attend either, is provided with written information and then completes a competency questionnaire. There is an attendance register for each training session and an individual staff member record of training. Education is linked to staff performance appraisals.</p> <p>Registered nurses are supported to maintain their professional competency. Three of nine registered nurses (including the acting facility manager and clinical nurse manager) have completed their interRAI training.</p>

		<p>There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies.</p> <p>There are 15 HCAs that work in the dementia unit. All 15 have completed their required dementia Careerforce (or equivalent) qualification. Out of a total of twenty-eight HCAs, nine have completed their level four Careerforce qualification (or its equivalent), eight have completed a level three qualification and three have completed a level two qualification.</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>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. The acting facility manager and CNM work full time at Radius Windsor Court (Monday – Friday). Interviews are currently underway to fill the facility manager’s role, which is intended to be an RN with a current practising certificate.</p> <p>RNs: There are two RNs on the AM and PM shifts and one RN on the night shift. When two RNs are rostered, they are each responsible for two wings. One is rostered for the dementia wing (15 residents) and one rest home/hospital wing (6 rest home and 5 hospital residents) and one is rostered for the other two rest home/hospital wings (22 rest home and 16 hospital). Three RN positions are in the process of being filled. The acting facility manager reported that this will put their staffing mix above what is budgeted and will assist in covering staff absences.</p> <p>HCAs: Sunshine (dementia): The morning and afternoon shifts are covered by two long (eight hour) HCAs, and the night shift is covered by one long HCA.</p> <p>Rest home/hospital wings: Five HCAs (four long and one short (0700 - 1300) are rostered on the AM shift, four long and two short (1500 - 2130) are rostered on the PM shift and two (long) HCAs are rostered on the night shift.</p> <p>Staff working on the days of the audit were visible and attending to call bells in a timely manner as confirmed by the residents interviewed. Staff reported that overall, the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers. Agency staff is used as needed and is kept to a minimum.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable,</p>	FA	<p>The resident files are 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 protected from unauthorised access. Electronic resident files (e-case) demonstrate service</p>

<p>accurately recorded, current, confidential, and accessible when required.</p>		<p>integration. Resident files are individually password protected and include the service users name, designation and time of entry.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. There is specific information available to families of dementia care residents. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. Admission agreements for long-term residents were signed and dated. The respite care resident had signed a short-stay 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>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB and the relatives. The service ensures appropriate transfer of information occurs. Relatives interviewed stated they are kept well informed and involved in any referrals for treatment options. 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>	<p>FA</p>	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. Medications were stored safely in the main medication room and the medication cupboard in the dementia unit. Registered nurses and level 4 HCAs administer medications and have completed annual medication competency and education. The RNs have syringe driver competency. Regular medications are dispensed in robotic rolls with as required medications in bottles/packets. The RN on duty completes a documented medication reconciliation for medications delivered. There were three self-medicating residents with completed medication competencies. There is a hospital stock of medications available. Telephone orders are used and signed by the NP/GP at the next visit. The medication fridge and medication room air temperature are monitored and recorded daily with both within the acceptable temperature range. Eye drops are dated on opening.</p> <p>Sixteen medication charts (paper-based) were reviewed (six hospital, six rest home and four dementia care) and met prescribing requirements. The allergy status and photo identification were on all medication charts. 'As required' medications had prescribed indications for use. The effectiveness of as required medications were documented in progress notes. The Radius group are awaiting the implementation of an electronic medication system linked to eCase with an expected roll out across facilities in September 2021.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals are prepared and cooked on-site. The kitchen manager (interviewed) works 8am to 4.30pm Monday to Friday and there is a qualified chef for the weekends. They are supported by morning and afternoon kitchenhands. All kitchen staff have current food safety certificates. The four weekly winter menu has been reviewed by a dietitian April 2021. There are two meal options for the main meal. The kitchen manager receives dietary information for all new residents and notified of any resident dietary requirements or weight loss. The chef meets with new residents. Special diets are accommodated and include pureed meals using Pure Foods and diabetic meals. Food allergies and dislikes are accommodated. Meals are served from the kitchen adjacent to the main dining room. Special equipment such as lipped plates is available. Meals may be served in rooms at resident requests. There is a satellite kitchen in the dementia unit. There are nutritional snacks regularly delivered and available in the dementia unit.</p> <p>There is current food control plan that expires 31 March 2022. The service uses an electronic tablet to record daily fridge, freezer, end cooked foods, inward goods and dishwasher rinse and wash temperatures. Internal audits are implemented to monitor performance. Residents and family members interviewed were happy with the meals and home baking provided. Residents and relatives have the opportunity to feedback through resident meetings and surveys.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<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, GP medical notes and allied health input is used to develop the initial interim care plan within 24 hours. Appropriate assessment tools have been completed on the eCase and reviewed at least six monthly or when there was a change to a resident's health condition. Behaviour assessments had been completed in the two-dementia level of care residents. Electronic care plans are developed on the outcomes of these assessments. An activity assessment is also completed for all new residents. InterRAI assessments had been completed for new</p>

		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, pain management plans and behaviour management plans for residents with dementia and behaviours of concern. Residents and their family/whānau confirm they are involved in the care planning and review process. The electronic progress notes evidence resident/relative involvement in care planning and reviews.</p> <p>Allied health involvement was linked to the long-term care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Moderate	<p>When a resident's condition changes the RN initiates a NP or GP consultation. Registered nurses interviewed stated that they notify family members about any changes in their relative's health status including accidents/incidents, infections, GP visits, appointments, medication changes and transfers to hospital. Family interviewed confirmed this. Care plans had been updated as residents' needs changed, however not all interventions had been implemented.</p> <p>Staff have access to sufficient medical supplies including dressings. Wound assessments, dressing plans, photos and evaluations were completed on the electronic system for 18 residents including skin conditions, five chronic venous ulcers and eight pressure injuries. There were two stage 2 (hospital level) and one unstageable pressure injury (dementia care) that were facility acquired. There were five community acquired stage 3 pressure injuries (two hospital residents). There was sufficient pressure relieving devices available including air alternating mattresses, foam booties and cushions. Monitoring charts evidencing two hourly repositioning as instructed on the work logs. Care plans describe pressure injuries interventions for residents at risk and with pressure injuries. The wound nurse specialist had been involved in the wound care of pressure injuries and chronic wounds.</p> <p>Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>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, re-positioning charts, behaviour charts and pain monitoring. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads, however not all neurological observations reviewed were completed as per protocol.</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 are two activities coordinators, one in the rest home and hospital and one who works in the dementia unit Monday to Friday from 7.30 – 3.30pm and they work alternate Saturdays. On Sundays the HCAs coordinate set activities on the programme and are involved in one-on-one time. There are plentiful resources. The activity coordinator in the dementia unit is enrolled to complete diversional therapy (DT) papers. There is communication and liaison with DTs at other regional Radius facilities.</p> <p>There are separate activity programmes for the rest home/hospital and the dementia care unit. The weekly programme is displayed in communal areas and in resident rooms. Residents have the choice of a variety of activities, in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include (but not limited to); exercises and strong and stable sessions with the physio, walks, floor games, quizzes, board games, music, movies, sing-a-longs, happy hours, crafts and baking. There are integrated activities that dementia unit residents can attend under supervision such as church services and entertainment. Community visitors include a library volunteer, entertainers, preschool children and pet therapy. There is a ladies knitting group who contribute to the community charities and a men's group who enjoy outings of interest including inter-home bowls. Community links are maintained with RSA, Lion's foundation group, Golden Hearts and working men's club. Outings are being re-established to places of interest and scenic drives. The service has a wheelchair van. Both activity coordinators have a current first aid certificate. Special events like birthdays, Easter, Matariki, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated.</p> <p>The dementia unit have tactile sensory boards in the hallways. The garden area has been upgraded with a concrete walking pathway. A sensory garden was completed late 2019.</p> <p>The activity coordinators do a meet and greet every morning with all residents. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. The resident under LTS-CHC has an individual leisure plan which describe the residents' individual interests, one on one activities and group activities they like to attend.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Each resident has a leisure plan which is reviewed six-monthly at the same time as the care plan. Resident meetings are held quarterly and open to families to attend. Feedback on activities was positive from both residents and families interviewed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</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, DT, keyworker RN, physio, GP and other allied health professionals involved in the care of the resident. There is a record of</p>

comprehensive and timely manner.		the MDT meeting which records if the resident goals have been met or unmet and changes to care to meet the resident goals. There is at least a three-monthly review by the NP/GP.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on electronic resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the NP/GPs and responded to in a timely manner. Referrals and options for care were discussed with the family as evidenced in interviews and e-case 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 DHB nurse specialists.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies 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. There is a chemical mixing dispenser. Staff have completed chemical safety training. There is one sluice room in the rest home/hospital unit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness which expires 17 June 2022. There is a full-time maintenance person Monday to Friday and available on-call and a full-time gardener. The maintenance person receives eCase notifications for maintenance requests and repairs. There are essential contractors available 24 hours who are familiar with the site. Testing and tagging of electrical equipment are completed two-yearly. Clinical equipment is calibrated annually. There is a planned maintenance schedule in place. Resident hot water temperatures are randomly checked monthly. Corrective actions have been documented for temperatures above 45 degrees Celcius.</p> <p>The communal areas in the rest home/hospital and the dementia unit are readily accessible for residents using mobility aids and for hospital residents being transferred in in lounge chairs. All seating was</p>

		<p>appropriately placed in communal lounge and dining areas. The external areas and gardens were well maintained. There is safe access to the outdoors for rest home/hospital residents. The dementia unit has a large fenced off garden with a concrete waling pathway, seating, and shade md raised gardens.</p> <p>Healthcare assistants interviewed stated they have adequate equipment to safely deliver care for all residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is a mix of ensuites, shared ensuites and use of communal shower/toilets. All rooms have hand basins. There are no ensuites in the dementia unit. Fixtures, fittings and flooring are appropriate. There is ample space in toilet and shower areas to accommodate shower chairs and in larger ones a hoist and shower trolley if appropriate. Communal shower/toilet doors have privacy signs.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents' rooms are single. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their</p>	FA	<p>There is a large dining room, large lounge and smaller lounge in the main rest home/hospital unit. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. Lounges open out onto the outdoor areas. In the dementia unit there are two lounges and a main dining room with a satellite kitchen safeguarded by a door barrier. There are exit/entry doors to the outdoor walking pathway. A hairdresser visits regularly.</p>

relaxation, 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>There is a laundry on-site for the laundering of delicates and woollens only. All other laundry including linen and personal clothing is laundered off-site at a commercial laundry. This is a five day pick up dirty laundry and 6-day delivery. The pickup is from the external laundry door and delivery into the facility at a separate door. There were adequate linen supplies available. There are three cleaners on duty Monday to Friday and one on the weekends from 7.30am to 3 pm who also do laundry duties. Cleaning trolleys were attended at all times and locked away when not in use. All chemicals on the cleaner's trolley were labelled. The chemical provider monitors the effectiveness of chemicals used. Cleaning and laundry services are monitored through the internal auditing system. Staff have completed chemical safety training.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. There is a minimum of one first aid trained staff member on every shift and during outings. The facility has an approved fire evacuation plan. Fire drills take place every six months. Fire safety is completed with new staff as part of the health and safety induction and is ongoing.</p> <p>Food stores are adequate for three days and water supplies are adequate for seven as per civil defence guidelines (note: an additional 600 litres of water was purchased during the audit in order to meet these guidelines). There is a gas barbeque and spare gas bottles. Civil defence bins/supplies are checked six-monthly.</p> <p>Resident's rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats, when activated, light up on corridor lights that are visible from all areas in the facility. Security policies and procedures are documented and implemented by staff. The building is secured at night and there is security lighting.</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</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. The facility is heated by a mixture of underfloor heating, heat pumps, and adjustable electric heaters in resident rooms. Staff and residents interviewed stated the temperature of the facility was comfortable.</p>

comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The clinical nurse manager is the infection control coordinator (IC coordinator) and has been in the role 15 months and held the role previously at another facility. Responsibility for infection control is described in the job description. The infection control coordinator oversees infection control for the facility and is responsible for the collation and reporting of monthly infection events to the infection control committee and monthly zoom meetings with the Radius Quality Manager for infection control. The infection control programme is reviewed annually by the Radius group in consultation with infection control coordinators.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the annual influenza vaccine and have received Covid vaccines. Covid screening and declarations continue.</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 IC coordinator has previous experience in infection control and recently completed outbreak management via on-line DHB Kowatea learning site for RNs. During Covid restrictions there were weekly zoom meetings and updates from head office. There is access to infection control expertise from within the Radius group, DHB infection control team, wound nurse specialist, laboratory, pharmacy and GPs. The infection control committee meet monthly and are representatives across the areas. Meeting minutes are available in the staff room. There is sufficient personal protective equipment available at the facility and at the head office.</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</p>	FA	<p>The infection control policies include a range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been reviewed last in April 2021 by an infection control specialist in the Radius group.</p>

practical, safe, and 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 infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme and ongoing thereafter. There has been additional education provided around outbreak management, handwashing techniques and donning and doffing of personal protective equipment.</p> <p>Resident education occurs as part of providing daily cares and as applicable at resident meetings. Residents and relatives were kept informed and updated on Covid restrictions and alert levels and visiting restriction.</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>Infection surveillance is an integral part of the infection control programme and is described in Radius' infection control policies. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly infection summary with an end of month analysis. A monthly report of antibiotic use is provided by the pharmacist. This data is monitored and evaluated monthly and annually and is provided to Radius head office. Outcomes and actions are discussed at management meetings and staff meetings and minutes are available to staff. Results from surveillance is used to determine education needs, resources required, and quality improvements required. Benchmarking occurs with other Radius sites.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The facility has undertaken a restraint-free philosophy. If restraint is used, it is as a last resort and is discontinued as soon as it is safe to do so. The CNM is the restraint coordinator and is responsible for assessing the need for restraint (if necessary), enablers (if requested by the resident) and for staff education.</p> <p>During the audit there were three (hospital) residents voluntarily using enablers (bedrails and lap belts for their wheelchairs) and no residents using restraints. One file of a resident using an enabler (bedrails) was reviewed. The assessment and consent process indicated that this restraint had been voluntarily requested by the resident to keep them safe in bed. Enablers (and restraints if any) are reviewed six-monthly.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>Electronic monitoring forms are completed and reviewed, for example, turning charts, food and fluid charts, blood pressure, weight charts and behaviour charts however not all monitoring charts had been implemented as documented or directed in the care plans. Not all neurological observations reviewed had been completed as per protocol.</p>	<p>(i) A 2-litre fluid restriction chart had not been implemented as per care plan for one hospital resident with cardiorespiratory conditions. The same resident did not have interventions in place to monitor weight loss since hospital admission, and (ii) there was no continuation of weekly weighs as per care plan for another hospital resident with weight loss, and (iii) Neurological observations had not been completed as per protocol for four of 11 unwitnessed falls.</p>	<p>(i). and (ii) Ensure monitoring charts are implemented as documented in care plans. (iii) Ensure neurological observations are completed as per protocol for unwitnessed falls.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.