

# Radius Residential Care Limited - Radius Kensington

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## 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 Kensington

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care

**Dates of audit:** Start date: 10 August 2021 End date: 11 August 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:** 88

# Executive summary of the audit

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## 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 Kensington is owned and operated by Radius Residential Care Limited. The service provides care for up to 96 residents requiring rest home, hospital, dementia level of care, and residential disability services - physical. On the day of the audit, there were 88 residents.

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

A registered nurse, with experience in aged care management, manages the service. A Radius regional manager and a clinical nurse manager support her. Residents and relatives interviewed spoke positively about the service provided.

This audit has identified one area for improvement around monitoring of observations.

## 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. A manager and a clinical nurse manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk

management programme is embedded 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 low risk.
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The service has assessment processes and residents' needs are assessed prior to entry. There is an admission pack available for residents and families/ whānau at entry. Assessments, residents care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms are being implemented. Resident care plans are individualised and include allied health professional involvement in care.

The activities coordinators implement the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. There are a variety of activities that are meaningful to the residents.

There are medication management policies in place. Staff responsible for administration of medications complete annual medication competencies and education. Medication charts have photo identification and allergy status noted. Medication charts are reviewed three-monthly by a general practitioner.

All food and baking are done on site. Resident`s individual dietary needs are identified and accommodated. Staff attend food safety and hygiene training.

## 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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There is an emergency management plan to guide staff in managing emergencies and disasters. Six monthly fire drills occur. Civil defence supplies are in place. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building has a current building warrant of fitness.

Resident rooms are personalised, and showers are spacious. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating. Communal areas within the facility are easily accessible. The outdoor areas are safe, accessible and provide seating and shade. Both dementia wings are secure.

There is one person on duty at all times with a current first aid certificate. Housekeeping staff maintain a clean and tidy environment. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. The laundry is done on site.

## 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 two 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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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.

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)
<b>Standards</b>	0	44	0	1	0	0	0
<b>Criteria</b>	0	92	0	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Radius Kensington 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 twenty-one staff (eight healthcare assistants [HCAs] who work during the AM and PM shifts in the rest home/hospital wings (four rest home/hospital and four dementia); six registered nurses (RNs); one enrolled nurse (EN); three activities coordinators; one maintenance staff; one laundry assistant; one kitchen manager) confirmed their understanding of the Code and could describe its application to their job role and responsibilities. Nine residents (four rest home and five hospital including one resident under the young person with a disability (YPD) contract) and eleven relatives (two dementia, six hospital, three rest home) interviewed confirmed that staff respect their privacy, and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and consent for outings. Permissions granted are also included in the admission agreements. There is documented evidence of discussion with the enduring power of attorney (EPOA) where the general</p>

<p>of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>practitioner has made a medically indicated not for resuscitation status. Copies of the residents' advance directive, where applicable, are on file. Four files from the dementia unit had copies of the activated EPOA on file.</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. The service is responsive to younger person with a disability (YPD) residents accessing community resources, facilities and mainstream supports such as education and public transport if able. On interview, staff stated that residents are encouraged to build and maintain relationships. The service promotes access to family and friends. Although visiting hours have been restricted from 10am to 4pm since the Covid-19 lockdown, all residents interviewed confirmed that relative/family visiting could occur at any time with their permission and the permission of staff.</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 manager. One complaint has been lodged in 2021 (year-to-date) and six were lodged in 2020. Three complaints reviewed in detail indicate that timeframes for responding to and investigating each complaint meet Health and Disability Commission (HDC) guidelines. One corrective action identified included staff training in relation to residents' cares. All complaints received are documented as resolved.</p> <p>A complaint lodged with HDC in 2019 has been signed off as completed with the complaint unsubstantiated. Corrective actions were implemented in relation to this complaint including purchasing 14 security cameras (external and internal), providing staff with additional training in relation to palliative care, and ensuring all HCA staff who work in the dementia units are enrolled for dementia training as a</p>

		<p>condition of their employment agreement.</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 manager or clinical nurse manager discuss 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>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 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. Residents interviewed confirmed their values and beliefs were considered. Young people with disabilities (YPD) are able to maintain their personal, gender, sexual, cultural, religious and spiritual identify, evidenced in an interview with one YPD resident (hospital) and review of one YPD resident file. 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 acknowledges their individual and cultural, values and beliefs.</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 (e.g., Rauawaawa Trust) as requested by the resident/family. For those residents who identify as Māori, cultural needs (e.g., spiritual, mental, physical, tikanga) are addressed in their resident-specific Māori health care plan. This care plan is signed either by the resident or their enduring power of attorney (EPOA).</p> <p>At the time of the audit, ten residents at the facility identified as Māori. These residents were unable to be interviewed but one family of a Māori resident (hospital) was interviewed and confirmed that the residents'</p>

		values and beliefs are respected. Links to whanau were evident in their Māori health plan. A kaumatua regularly visits the facility. HCAs interviewed were able to identify specific Māori cultural values and beliefs that were upheld, specific to each individual resident who identified as Māori. Cultural events are celebrated as part of the activities programme (e.g., Matariki). A kapahaka group visits the facility as well as a local intermediate school cultural group.
<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>Cultural education is an annual in-service topic that staff are required to attend (course content sighted). The annual resident satisfaction survey monitors the residents'/family satisfaction levels in relation to meeting their cultural needs. Survey results indicate that this is fully attained.</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>	FA	<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>	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. 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) is onsite two 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. This has included the development of a training guide that is being shared with three other Radius facilities. Staff are rostered to attend two full days of (paid) training. External training is organised for specific areas and is included in the annual training calendar (e.g., palliative care, first aid/CPR). 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 days and attending toolbox talks during shift handovers.</p>

		<p>A monthly analysis of quality data results (e.g., falls, infections, pressure injuries, complaints received) is reported each month. Residents' falls are analysed with input provided by a physiotherapist who is available two days a week (12 hours). Staff are kept informed regarding at-risk residents through the e-case electronic programme, at staff handovers, and in staff meetings.</p> <p>The latest resident satisfaction survey (June 2021) results (sample size 17) indicated that almost all residents are satisfied or very satisfied with the services they are receiving and would recommend Radius Kensington to a family member or friend. No corrective actions were identified.</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 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.</p> <p>A quality improvement was implemented in relation to improving communication with families following results received from a resident/family satisfaction survey (2018). The clinical nurse manager (CNM) at the time developed a communication strategy to ensure that the family are included in the treatment and care plan of their family member. This has resulted in subsequent improvements on satisfaction survey scores in relation to communication between the facility and families.</p> <p>There is an interpreter policy in place and contact details of interpreters are available. At the time of the audit, there were two residents who were unable to speak/understand English. Some staff are available to interpret in addition to family. Signs are also used to assist with translation. HCAs interviewed were able to recite the words that they have learned to assist with communication.</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 Kensington is a Radius aged care facility, located Hamilton. The facility is certified to provide rest home, hospital (medical and geriatric) dementia levels of care and residential disability services - physical for up to 96 residents. During the audit there were 88 residents.</p> <p>The secure dementia wings had 31 residents (17 in one wing and 14 in the other wing), and the two rest/home hospital (dual-purpose) wings had 10 rest home level residents and 47 hospital level residents. Three residents were funded by the Ministry of Health on a young person with a disability (YPD) contract, three residents (hospital) were funded by ACC, and three residents (one hospital, two dementia) were funded by the DHB on a long-term support – chronic health condition contract (LTS-CHC). The remaining residents were on an age-related residential care agreement.</p> <p>The Radius philosophy and strategic plan reflects a person/family centred approach. The current 2021</p>

		<p>annual business plan for Radius Kensington 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 manager is an RN who undertook this role in January 2021. Prior to this she was the CNM for this facility and a senior RN over a period of three years. The CNM has been in their role since January 2021 and has worked as an RN at Radius Kensington for over three years. Section 31 reports were filed to HeathCERT (Ministry of Health) to notify them of the managerial changes at Radius Kensington.</p> <p>The manager and CNM have maintained at least eight hours of professional development activities related to their role and responsibilities.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The CNM covers during the absence of the manager. Additional support is provided by the Radius national quality manager who was 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>	FA	<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. YPD residents have input into quality improvements to the service. Satisfaction with choices, decision-making, access to technology, aids, equipment and services contribute to the quality data collected by the service. Resident/family meetings are held two-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 2021 (17 residents and family responded). Survey results reflect overall satisfaction. No corrective actions were identified.</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 staff who deliver care.</p> <p>The quality programme is designed to be monitored against contractual and health and disability</p>

		<p>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 in eight weeks to evidence the effectiveness of the corrective action(s) implemented. This is repeated 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 has completed stage four training was interviewed. She assists with all health and safety monitoring activities (e.g., physical health and safety risk inspection (six-monthly, facility health check (six monthly), environment inspection (six monthly). 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 health and safety training begins during their orientation and continues annually. Contractors are orientated to health and safety processes either by the manager or maintenance staff.</p> <p>Falls prevention strategies are in place including (hourly) intentional rounding, sensor mats, post falls reviews and resident-specific interventions. Physiotherapy input is provided for residents who are at high risk of falling.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>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, medication error) 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 six of thirteen unwitnessed falls (link 1.3.6.1). The clinical nurse manager signs off on all adverse events which indicates that the event is closed.</p> <p>The manager is able to identify situations that would be reported to statutory authorities including changes in management (two), stage three and unstageable pressure injuries (three) and physical aggression (five). There have been two gastro-intestinal outbreaks over the past two years with the DHB and public</p>

		health authorities notified.
<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. Nine staff files reviewed (three staff RN, five HCAs, one kitchen hand) included a defined recruitment process which included reference checking; signed employment contracts and job descriptions; police checks; completed orientation programmes; and three-monthly 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 as a toolbox talk during shift handovers. 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. Four of fourteen registered nurses (including the manager and clinical nurse manager) have completed their interRAI training. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies.</p> <p>There are 21 HCAs that work in the dementia unit. Seventeen have completed the required dementia Careerforce (or equivalent) qualification and four HCA staff who have been employed less than 18 months are enrolled. Out of a total of forty-seven HCAs, eleven have completed their level four Careerforce qualification (or its equivalent), fourteen have completed a level three qualification and two 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 manager and CNM work full time at Radius Kensington (Monday – Friday). At the time of the audit there was an RN vacancy in dementia for three days a week.</p> <p>There are two separate dementia wings with 19 beds each, 17 residents in one secure wing (including one YPD) and 14 in the other secure wing at the time of the audit. An RN is rostered to cover both wings on the AM shift on Wednesdays and Thursdays and an enrolled nurse (EN) covers on Mondays and Tuesdays. Two HCAs are rostered in each wing on the AM and PM shifts and one HCA is rostered in each wing during the night shift, seven days a week.</p> <p>There are two rest home/hospital (dual-purpose wings). The orange wing has 29 beds, with 28 residents; (four rest home and twenty-four hospital) is staffed with an RN on the AM, PM and night shifts. Three long</p>

		<p>(seven-eight hour) and one short (to 1330) shift HCAs are rostered on the AM shift; three long and one short (1630 – 2200) are rostered on the PM shift and one HCA is rostered on the night shift.</p> <p>The yellow wing has 29 beds with 29 residents; (six rest home (including one YPD) and twenty-three hospital (including one YPD) is staffed with an RN on each shift (24/7). In addition, an EN is rostered on the PM shift on Thursdays and Fridays. HCA staffing the same as the staffing on the orange wing.</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, accurately recorded, current, confidential, and accessible when required.</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 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>	FA	<p>There are pre-entry and admission procedures in place. All resident files evidenced approval for the level of care by the need's assessment coordinators. The clinical nurse manager liaises closely with the assessing teams to ensure the service can meet the assessed resident needs.</p> <p>The service has a well-presented information booklet for residents/families at entry. Information includes family support programmes and contact details for advocacy to support and younger people with physical disabilities. Six family members interviewed stated they received sufficient information on the services provided and were appreciative of the staff support during the admission process.</p> <p>Admission agreements had been signed within a timely manner. Ten admission agreements reviewed align with all contractual requirements. Exclusions from the service are included in the admission agreement. Four residents from the dementia wing had activation letters for enduring power of attorney integrated within their file.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>The transfer /discharge/exit procedures include a transfer/discharge form, and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident. Hospital discharge</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>documentation is integrated in the resident file and care plan.</p>
<p><b>Standard 1.3.12: Medicine Management</b></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>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All medicines are stored securely. Registered nurses and healthcare assistants complete annual medication competencies and medication education. The medication room is near one of the nurse's stations. RNs complete the administration of medication; there are four lockable medication trolleys. A recent medication management internal audit was completed with no corrective actions or medication errors/ incidents.</p> <p>The RNs are responsible for medication reconciliation against the medication packs for regular and 'as required' medications. Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. The medication fridge temperature and medication room temperature are being monitored daily and both were within acceptable limits. There are procedures in place to facilitate safe self-administration of medication for four residents (inhalers). There are no medication standing orders in use. All eye drops were dated on opening.</p> <p>Twenty electronic medication charts were reviewed across all wings. All medication charts had photo identification and an allergy status. The GP reviewed the medication charts at least three-monthly. Prescribed 'as required' medications included the indication for use and the effectiveness was recorded in the progress notes. Nutritional supplements are documented and administered from the medication chart.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a large commercial kitchen, and all food is cooked on-site. There is a comprehensive kitchen manual in place. There is a full-time kitchen manager (qualified chef) and supported by a weekend cook. They are supported by three kitchenhands. There is a seasonal menu in place. A dietitian has reviewed the menu. The service has a verified food control plan that expires on 31 March 2021.</p> <p>The kitchen manager receives a dietary profile for each resident with dietary requirements, special diets, food allergies, likes and dislikes. The kitchen manager interviewed is knowledgeable regarding specific residents needs including those with diabetes, unintentional weight loss (or gain) and recent dietician input. Alternatives are offered. The kitchen manager is notified of any dietary changes for the residents. Dietary profiles kept in the kitchen is reflective of the current nutritional needs of the residents.</p> <p>Lip plates are provided to encourage resident independence with eating. There is an overnight store cupboard where staff can access additional foods. Adequate fluids are delivered to the kitchenette fridges including smoothies and thickened fluids. There were "finger foods", yoghurts, ice-cream, sandwiches,</p>

		<p>and home-baking readily available for the dementia care residents.</p> <p>Food is plated in the kitchen and transported in hotboxes to the dining rooms. The workflow and space in the kitchen are adequate and promote efficiency. There are three dining areas are large enough for residents, mobility equipment and individual wheelchairs. Special diets are plated and labelled. The fridge and freezer have visual temperatures, which are recorded daily. The facility fridges temperatures are monitored (records sighted). Temperature of food on delivery is recorded.</p> <p>The late afternoon meal was observed in the blue wing. The staff assisting residents with their meals promoted and encouraged dining room ambience. There were enough staff to assist with meals in a timely manner and specialised cutlery was available. Residents that may eat slower, food were kept in the hotboxes to maintain the ideal state and temperature of the food before it was served.</p> <p>Feedback on the quality of meals is by direct verbal feedback, annual surveys and as an agenda item at residents and family meetings. The food and meal survey completed in June 2021 showed overall resident satisfaction with the food choices and meals. There were no corrective actions required.</p> <p>Staff working in the kitchen have food handling certificates and receive ongoing training.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or if there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The RNs completes an initial assessment on admission including risk assessment tools as appropriate. An interRAI assessment is undertaken within 21 days of admission and every six months. Resident needs, support and goals are identified through the on-going assessment process and form the basis of the long-term care plan. There were regular pain assessments evident for a resident with complex co-morbidities, all four files reviewed for the dementia wing had behaviour assessments completed within 24 hours of admission as per Radius care plan and documentation policy.</p> <p>Residents interviewed confirmed their preferences and choices are accommodated during their care journey. The information gathered at admission such as allied health notes, needs assessment, discharge summaries and discussion with the EPOA and the resident, is used to develop care needs and support to provide best care for the residents. An initial assessment covers all activities of daily living and specific</p>

		<p>assessment tools are used for behaviour, falls risk, nutritional risk, pain assessment and communication tool. The physiotherapist completes an initial mobility assessment for all residents on admission and reviews residents post falls and at least six-monthly. The falls risk assessment tool is repeated for any resident with three falls or more in a month. YPD residents' long-term mobility, seating and postural support needs are assessed with the resident (where able) and their family/ whānau. The initial 'about me' and 'leisure assessment' include details around community involvement, cultural and spiritual needs.</p> <p>Resident files reviewed included an individual assessment that includes identifying diversional, motivation and recreational requirements to maintain community involvement and engagement, according to the resident's preference and choice. Behaviour assessments, spiritual and cultural needs had been completed as part of the assessment process. The one YPD resident interviewed stated the service assists to maintaining a normal routine and community engagement.</p> <p>The activities coordinators complete a comprehensive social assessment in consultation with the resident/family.</p> <p>All four files reviewed of residents in the dementia wing had a completed activities assessment, 24-hour diversional therapy plan and behaviour assessments chart (where applicable) completed within the stated timeframes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans are developed in consultation with the resident, family, activity coordinator and other allied health input (including discharge notes, GP instructions, community interRAI assessments).</p> <p>InterRAI assessment triggers and the outcome scores forms the basis of the long-term care plan. Care interventions are detailed to a level that supports their individual needs and goals. Assessment outcomes were included in the long-term care plans reviewed. The long-term care plan identifies interventions that cover a set of goals including managing medical needs/risks.</p> <p>Alerts on the resident's profile page identify current and acute needs such as (but not limited to); allergies, advance directives, current infection, wound or falls risk. Short-term needs are added to the long-term care plan. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration.</p> <p>One resident (hospital) had a specific plan for unintentional weight gain. Communication needs are documented for those residents with speech impairments. Staff interviewed are knowledgeable about all individuals in their care and the care approaches they require. HCAs interviewed confirmed they have received education in effective communication to care for younger residents with disabilities. Staff were also observed in the dining room interacting with the residents in a respectful manner.</p>

		<p>Short term care plans are utilised for short term needs including weight loss, wound care, infections and eye care. Short-term care plans are signed off when the issue is resolved.</p> <p>All files reviewed for residents in the dementia wing include a 24-hour activity plan and recreational plan with documented individual daily routine. For those residents that present with challenging behaviours; triggers, and activities to distract and de-escalate behaviours are documented with associated risks. There was evidence of allied health care professionals involved in the care of residents including physiotherapist, podiatrist, dietitian, specialist dementia services, diabetes nurse, respiratory nurse and an occupational therapist. The contracted physiotherapist review residents for mobility support and seating requirements and will refer if required.</p> <p>The GP, dietician and allied health professional progress notes were evident in the resident's files sampled. Progress notes document family involvement. Any change in care required is documented and verbally passed on to relevant staff.</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>	<p>PA Low</p>	<p>Documentation, observation and interview with the RNs verified that care provided to the residents is consistent with their needs, goals and plan of care. The interview with the GP confirmed that discussion and referral to allied health professionals took place in a timely manner. When medical input was required, notification occurred promptly, and any medical orders were appropriately carried out. Family/whānau expressed during interview that assistance was given according to the wishes of their relatives.</p> <p>Specialised equipment including sensor mats, hoists (standing and full), transfer belts, lap belts, pressure relieving mattresses and cushions were available for use. There is a process where equipment (including individualised equipment used by the YPD residents) is checked for safety and maintained by the appropriate services. The service maintained a record of when equipment is calibrated and serviced.</p> <p>Continence, wound care products and PPE were in stock for use. Staff received annually education in continence management and wound care management.</p> <p>The wound register was reviewed and current; an updated wound care policy including pressure injury management, management of skin, nutrition and hydration needs were reviewed. Wound assessment and wound management plans were in place for thirty-three (across services). There were fifteen minor skin tears, four lacerations, eight pressure injuries, two surgical wound and four other skin conditions documented and unresolved in the wound register.</p> <p>The eight pressure injuries include two stage one (rest home and hospital), five stage two (four hospital and one dementia) and one unstageable pressure injury. There was evidence of resolved pressure injuries. Two (one stage one and one stage two) pressure injuries were on the sacrum, all other pressure injuries were classified as pressure injuries, involve the feet and comorbidities (diabetes, renal failure)</p>

		<p>were documented as contributing factors. Skin assessments, nutritional assessments, regular pain assessments and wound assessments are in place for all complex wounds. Wound assessments, plans and reviews are current and completed. Dressings were undertaken in the stated timeframes. Registered nurses interviewed were aware of when and how to get specialist wound advice when needed. There was evidence of input from a wound nurse specialist and diabetes nurse specialist for six residents.</p> <p>Monitoring records include (but not limited to) weight, catheter changes, food and fluids, blood sugars, turn charts behaviours and routine observations including neurological observations after unwitnessed falls. Monitoring forms are completed as required; however, the neurological observations following an unwitnessed fall had not been completed as required.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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 three activities coordinators that work Monday to Fridays (8.30am-4.30pm). All are responsible for documentation completion and spends one on one time with residents. One activities coordinator focusses on exercises and mobility and works closely with the physiotherapist.</p> <p>Care plans acknowledge spiritual and culture needs. There is an integrated rest home/hospital and separate programme for the dementia wing scheduled across six days. Activities are provided between 9am- 4.30 pm Monday to Saturdays.</p> <p>There is music therapy on a Monday in the dementia wing and combined group activities with rest home and hospital residents from Tuesdays to Fridays. There is an entertainer scheduled for Saturdays and HCAs assist with activities during the weekend. HCAs interviewed confirm they have access to the activity's cupboard with board games, floor games and DVDs. There is one regular volunteer that assist with various activities.</p> <p>Residents are accompanied to community involvement activities. The activities staff have one-on-one time with residents who are unable or who choose not to participate in the programme. The younger people with disabilities are supported to maintain community links and this is reflected in their care plans.</p> <p>The activities staff at Radius Kensington provides an activities programme encompassing links to the restorative model of care and enabling strong community links for the residents. The diverse cultures within the facility are incorporated within the programme. A monthly activities calendar is distributed to residents and is posted on noticeboards. Group activities are voluntary and developed by the activities staff in consultation with the residents (including YPD), healthcare assistants and registered nurses. Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities and is age appropriate. A number of clubs and groups have been initiated by residents including the younger people. Activities are purposeful and focussed to decrease depression, challenging behaviour and mindfulness. There is evidence of pastoral care through the provision of church services. Activities included cultural days, celebration of events, Olympic games, reflexology, `armchair travel`.</p>

		<p>There was evidence of engagement with artistic activities.</p> <p>Activities for younger people are documented to the extent that is clinically appropriate and do reflect the resident's former routines and community engagement including Māori community links, cultural and spiritual needs. Younger people are supported to access community groups.</p> <p>Special interest groups include a creativity group and art group.</p> <p>The activity staff completes an initial assessment and resident profile, an activity care plan, and a 24-hour activities plan. Evaluations are completed six-monthly as part of the multidisciplinary team review. Activities are varied to meet the needs of the groups of residents at the service. The service has a van which is used for resident outings and trips into the community</p> <p>Residents and relatives interviewed spoke positively of the activity programme with feedback and suggestions for activities made in resident meetings. Residents were observed participating in floor games.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The initial care plan is evaluated in consultation with the resident/ relative and long-term care plans developed. Long-term care plans reviewed had been evaluated six monthly or earlier for any changes to health. The resident/relative are invited to attend the multidisciplinary review with the clinical nurse manager, RN, healthcare assistants and activities coordinators. There is a written evaluation against the resident goals that identifies progression towards meeting goals. Long-term care plans are updated with any changes to meet the resident goals. Short-term care plans were evident for the care and treatment of short-term problems for residents, and these had been evaluated, closed or transferred to the long-term care plan if the problem was ongoing.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Radius Kensington access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. There was evidence of referrals to the dietitian, specialist dementia nurse, occupational therapist, wound care specialist, continence advisor, ear health nurse, physiotherapy and the podiatrist.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents and forms are completed by staff. There are no incident/accident reports reviewed involving waste, infectious material, body substances or hazardous substances.</p> <p>There is an emergency plan to respond to significant waste or hazardous substance management.</p> <p>All chemicals sighted were appropriately stored in locked areas. Chemicals supplied are appropriately labelled. Sufficient gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn.</p> <p>The current systems for managing waste and hazardous substances are satisfactory.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires July 2022. The service employs a full-time maintenance person who is a health and safety representative, who is on call 24/7 for any maintenance issues. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained that includes internal and external building maintenance. Electrical testing is completed two-yearly. An external contractor completes annual calibration and functional checks of medical equipment.</p> <p>The facility's amenities, fixtures, equipment and furniture are appropriate for the level of service contracted. There is sufficient space to allow residents to move around the facility freely. The hallways have handrails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Residents' bedrooms throughout the facility have resident's own personal belongings displayed. External areas and garden areas surrounding the facility are well maintained. Level paths to the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained.</p> <p>The two dementia wings are secure, and each has an attractive secure courtyard.</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</p>	<p>FA</p>	<p>There are an adequate number of toilets and showers in each wing. All bedrooms have hand basins. There are a mix of rooms with ensembles and shared communal facilities. There are adequate numbers of toilets and shower rooms with vacant/in-use slide signs for privacy. Residents interviewed, confirmed their privacy is assured when staff are undertaking personal cares. There are soap dispensers in all bathrooms. There are separate staff/visitors' toilets. There is signage to promote effective hand washing techniques in the staff and visitors' toilet. There are alcohol pumps available throughout the facility. The</p>

attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		facility was clean, well presented and odour free.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate space in all bedrooms for residents and staff. Healthcare assistants confirmed they could move freely to provide cares and there is enough space to move mobility equipment safely. Doorways into residents' rooms and communal areas are wide enough for wheelchair, power wheelchairs, ambulance trolley and bed access. Residents interviewed stated they are happy with their rooms.
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 service has a main lounge and a dining room in the yellow, blue and green wing. There are smaller lounge areas within the facility. Residents were seen to be moving freely throughout the facility. Residents can move freely from their bedrooms to communal rooms and the outside. Internal and external doorways are level with pavements, which allows wheelchair access. Activities occur in the main lounges and residents can access their rooms for privacy when required. Residents stated that they are happy with the layout of the hospital. There are large sunny lounges, spacious dining room areas and outdoor access and this is satisfactory to meet the needs of all resident groups.
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	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There is a dedicated laundry staff and cleaners on duty seven days a week. There are sluice rooms in each wing for the disposal of soiled water or waste. On the day of the audit, these were locked when unattended.  The laundry and cleaning staff have completed chemical safety training. The laundry is located in the rest home/hospital wing and has a sluice area with appropriate personal protective clothing readily available. There is an entry and exit door with defined areas for clean and dirty laundry. The cleaner's trolleys are stored in a locked area when not in use. Internal audits monitor the effectiveness of the cleaning and laundry processes. The chemical supplier conducts quality checks on the effectiveness of washing and cleaning processes  The cleaners' rooms are designated areas are locked when not in use and all chemicals are clearly labelled.

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. The services emergency plan considers the special needs of the residents including the YPD residents in an emergency. There is a minimum of one first aid trained staff member on every shift and during outings. The facility has an approved fire evacuation plan. Fire drills take place every six months. 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 DHB guidelines. There are three gas barbeques 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. Sixteen security cameras are installed, both outdoors and indoors.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and resident rooms are appropriately heated and ventilated. The facility has thermostatically controlled wall mounted heaters in each resident room and heat pumps in communal areas. All bedrooms and communal areas have at least one external window. The indoor temperatures were pleasant and warm.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control (IC) programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse has been in the role for twelve months (and as a RN for over four years) and has a job description outlining the responsibilities of the role. She is supported by an infection control committee, clinical nurse manager and the Radius national quality manager at support office. The infection control programme is discussed monthly and discussed at monthly RN, quality and health and Safety committee meetings. The IC programme is annually reviewed at an organisational level.</p> <p>There is a Covid-19 prepared plan according to risk levels. Visitors are asked not to visit if unwell. There is QR screening and declarations in place for all visitors, staff and contractors. Hand hygiene notices are in use around the facility and there are hand sanitizers strategically placed throughout the building. Relatives have been kept updated on visiting policies.</p> <p>Residents and staff had been vaccinated against Covid-19. Each resident had a short-term care plan to</p>

		guide staff in reporting any adverse effects after vaccinations were completed.
<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	The monthly infection control committee meeting includes representatives from across the services. The committee meet monthly, and data is discussed and published in the monthly minutes and graphs that are available to all staff. The infection control nurse has completed Covid-19 online learning and formal infection prevention and control learning. The service also has access to an infection control and prevention team at the DHB, Public Health, GPs and local community laboratory infection-control team.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	There is an infection control manual, which includes policies and procedures appropriate for the size and complexity of the service. Policies are reviewed at head office in consultation with all infection control nurses. Any changes or updates to the infection control policies are notified at staff meetings and are recorded in the staff meeting minutes. There is a Radius Covid-19 policy and outbreak management plan in place.
<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	The infection control nurse with support from the clinical nurse manager is responsible for coordinating/providing education and training to staff. All staff receive infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control hand-hygiene competency annually. There has been additional Covid-19 training including weekly meetings when risk level changes, the correct use of personal protective equipment and donning and doffing competencies. There is an infection control focus every month which includes in-service training.
Standard 3.5: Surveillance	FA	Infection surveillance is an integral part of the infection control programme and is described in Radius

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>Kensington infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Care plans for the management of infections are added to the long-term care plan. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner. The infection control nurse interviewed reports the service works actively on reducing the high rate of urine tract and skin infection at the time of the audit. Reports are easily accessible to the management team and support office staff.</p> <p>Two gastro outbreaks were reported one in February 2020 and one in July 2021. Both episodes were of short duration, less than ten days and managed appropriately and reported to the local public health authority.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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 two (hospital) residents voluntarily using enablers (bedrails) 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 regularly monitored and reviewed every month.</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>	PA Low	<p>Care plans include frequency of monitoring when this is required. Radius falls assessment and intervention policy states “if the resident sustained trauma to the head or the fall is unwitnessed, the resident must be monitored. Neurological recordings should be taken hourly for the first four hours and if stable four hours for the first 48 hours.”</p> <p>Thirteen incident forms (five rest home, seven hospital and one dementia) related to an unwitnessed fall were reviewed, six post fall neurological observations were not completed according to protocol.</p> <p>One resident (rest home) sustained a head injury following a fall in the early morning however the neurological observations were only commenced five hours after the fall by the next shift RN. This resident already had a diagnosed subdural bleed, major head laceration and lower respiratory tract infection following discharge after another fall two weeks prior to the last fall. The resident was in hospital at the time of the audit.</p>	Six (three rest home and three hospital) post fall neurological observations were not completed as required.	<p>Ensure neurological observations are completed as per protocol where a resident had an unwitnessed fall or sustained a head injury.</p> <p>60 days</p>



## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.