

# Radius Residential Care Limited - Radius Elloughton Gardens

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

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

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

The specifics of this audit included:

**Legal entity:** Radius Residential Care Limited

**Premises audited:** Radius Elloughton Gardens

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

**Dates of audit:** Start date: 10 April 2018 End date: 11 April 2018

**Proposed changes to current services (if any):** As part of this audit the service was verified as suitable to provide medical level care under their hospital certification

**Total beds occupied across all premises included in the audit on the first day of the audit:** 77

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

## General overview of the audit

Radius Elloughton Gardens is owned and operated by Radius Residential Care Limited. The service provides care for up to 86 residents requiring rest home or hospital level care. On the day of the audit, there were 77 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, management and general practitioner. As part of this audit the service was verified as suitable to provide medical level care under their hospital certification.

The service is managed by a facility manager who is a trained social worker experienced aged care manager. He has been at the service for three years. The facility manager is supported by the clinical manager who has been in the role since March 2016 and the Radius regional manager. Residents and relatives interviewed spoke positively about the service provided.

There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who live in the service. Implementation is supported through the organisational quality and risk management programme. Quality initiatives are implemented which provide evidence of improved services for residents.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

The facility has embedded the interRAI assessment protocols within its current documentation. Resident files included service integration and input from allied health and specialists.

The service has been awarded two continued improvement ratings around quality initiatives and the activities programme.

## 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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The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review process. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed, verified ongoing involvement with community.

## 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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A facility manager and clinical nurse manager are responsible for the day-to-day operations. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities, including Radius key performance indicators, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Resident meetings are held regularly, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An education and training programme has been implemented with a current plan in place. An orientation programme is in place for new staff. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care. Residents and families report that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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The facility manger and clinical manager primarily manage entry to Elloughton gardens. There is comprehensive service information available. A registered nurse completes initial assessments. The registered nurses complete care plans and evaluations within the required timeframe. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed, confirmed they were involved in the care planning and review process.

Each resident has access to individual, group and small group activity programmes that meets the recreational needs of the residents.

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

in line with appropriate guidelines and regulations. General practitioners review residents at least three monthly or more frequently if needed.

Meals are prepared on-site by a contracted service. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy, and several have their own ensuite in the older wings. All rooms have their own ensuite in the newer wing. There is sufficient space to allow the movement of residents around the facility using mobility aids, including for residents at hospital level care in any rooms. There are a number of small lounge and dining areas throughout the facility in addition to two larger communal areas. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management.

The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted.

## 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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. At the time of the audit there were five residents using six restraints and there were no residents using an enabler. Staff receive regular education and training on restraint minimisation.

## 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 evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. An outbreak in August 2016 was appropriately managed and reported.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	49	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Discussions with 11 care staff, including five health care assistants (HCA), four registered nurses (RN) and two activities coordinators, confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Nine residents (two rest home and seven hospital) and three relatives (all hospital) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their EPOA. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Health care assistants and registered nurses interviewed 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>All nine resident files sampled, two rest home and seven hospital residents had a signed admission agreement and consents.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (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>	FA	<p>Residents and relatives interviewed, confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, (e.g., attending cafes, and restaurants). Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility. There is a complaint's register that includes relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings. There have been 17 complaints made in 2017 and three received in 2018 year-to-date. The complaints reviewed included follow-up meetings and letters, resolutions were completed within the required timeframes as determined by the Health and Disability Commissioner.</p> <p>A complaint made through the Health and Disability Advocacy Service in 2016 was reopened and channelled through the Health and Disability Commissioner (HDC) in March 2017. No formal action was taken but a number of recommendations only were made by HDC. The complaint has been investigated and followed up with a corrective action plan in place (which has been communicated to HDC). Key actions covered in the corrective action plan included; i) RN training completed around the process of contacting/including next of kin in regular multidisciplinary meetings, ii) registered nursing staff to complete training for PEG external feeding to align with DHB requirements once the facility has a resident requirement to do so, iii) conducted staff training around communication policy to improve communication with families, iv) implemented clinical documentation improvements in relation to intentional rounding v) facility manager and 44 staff attended Code of Rights training in July 2017, and vi) regional manager sent a formal apology letter to the complainant on 16 March 2018.</p>

Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights.	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code of Rights. Monthly resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. The 2017 satisfaction survey identified 90% of residents were happy with privacy. Contact details of spiritual/religious advisors are available. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided, last occurring in March 2017.
Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Elloughton Gardens has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of audit there were no residents who identified as Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Māori consultation is available through a local Māori Kaumātua who visits on a weekly basis.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values. The 2017 satisfaction survey identified 84% outcome for cultural/spiritual needs being met.
Standard 1.1.7: Discrimination	FA	Staff job descriptions include responsibilities, and staff sign a copy on employment. The quality meetings occur monthly and include discussions on professional boundaries and concerns as they arise.

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.		Management provide guidelines and mentoring for specific situations. Interviews with the facility manager, clinical nurse manager and RNs confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The Radius quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. Policies and procedures have been reviewed and updated at organisational level and are available to staff. Staff meetings and residents' meetings have been conducted. Residents and relatives interviewed spoke very positively about the care and support provided. Staff had a sound understanding of principles of aged care and state that they feel supported by the facility manager, clinical nurse manager and nursing staff. There are implemented competencies for health care assistants and RN. There are clear ethical and professional standards and boundaries within job descriptions.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the health status of residents and incidents/accidents and incident forms sampled confirmed this. Resident/relative meetings are held monthly. The facility manager and the clinical nurse manager have an open-door policy. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Elloughton Gardens is part of the Radius Residential Care Group. Elloughton Gardens cares for up to 86 residents requiring hospital and rest home level care. Seventy-four rooms can be used for either hospital or rest home level care. On the day of the audit, there were 77 residents in total, 17 rest home level residents, including one on a long-term support chronic health conditions (LTS-CHC) contract, and 60 hospital residents including one funded by ACC, one on palliative care, one on a LTS-CHC contract, one on a 'younger persons with disability' (YPD) contract and one on respite care. All other residents were on the aged related residential care (ARRC) contract.</p> <p>As part of this audit the service was verified as suitable to provide medical level care under their hospital certification.</p> <p>The Radius strategic plan describes the vision, values and objectives of Radius aged care facilities. The service organisation philosophy and strategic plan reflect a person/family-centred approach. A business</p>

		<p>plan April 2017 to March 2020 for Elloughton Gardens, describes specific and measurable goals that are reviewed each month at the quality meeting. The business plan is updated annually.</p> <p>The facility manager has been in the position for three years and has more than 20 years' experience in management roles with the health sector. He is supported by a clinical nurse manager who has been in the role for two years and a regional manager who has been in the position for three years.</p> <p>The facility manager has maintained more than eight hours of professional development activities related to managing an aged care facility.</p>
<p><b>Standard 1.2.2: Service Management</b></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>In the absence of the facility manager, the clinical nurse manager is in charge with support from the regional manager and care staff. A review of the documentation, policies and procedures and from discussions with staff identifies the service's operational management strategies, and quality and risk programme are in place to minimise the risk of unwanted events and enhance quality.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is an organisational business plan that includes quality goals and risk management plans for Elloughton Gardens. Quality and risk performance is reported across facility meetings and to the regional manager. The facility manager advised that he is responsible for providing oversight of the quality programme. There are monthly staff and quality meetings where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff. Required actions and resolutions from facility meetings are documented. Resident/relative meetings are held monthly. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The overall service result for the resident/relative satisfaction survey completed in November 2017 was at 80%. A corrective action plan was developed and implemented around areas identified as below the national average, (i.e., around food services and cleaning).</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. The clinical managers group, with input from facility staff, reviews the service's policies at national level every two years. Clinical guidelines are in place to assist care staff. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. Data is collected in relation to a variety of quality activities and an internal audit schedule</p>

		<p>has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions are evaluated and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. The health and safety representative (maintenance person) interviewed confirmed his understanding of health and safety processes. He has completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. Radius has achieved tertiary level ACC Workplace Safety Management Practice. Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions. An effort has been made to reduce falls by establishing a falls prevention co-ordinator role, and the monthly analysis of falls data.</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. Incidents are included in the Radius key performance indicators (KPI). There is a discussion of incidents/accidents at monthly staff and quality meetings, including actions to minimise recurrence. A review of twelve incident/accident forms from March 2018 identified that forms are fully completed and include follow-up by a RN. Neurological observations are carried out as per protocol for any suspected injury to the head. Discussions with the facility manager and regional manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been a total of five pressure injury section 31 notifications to MoH, four of which were non-facility acquired.</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. Nine staff files reviewed (one clinical nurse manager, two RNs, three HCAs, two activities coordinators and one maintenance person) include a recruitment process which included reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals. A register of RN staff and other health practitioner practising certificates is maintained. Registered nurses are supported to maintain their professional competency.</p> <p>Clinical portfolios have been assigned to some registered nurses. These give leadership functions for: Falls prevention; infection control; and restraint minimisation.</p> <p>The orientation of new staff has been revised and a more comprehensive programme is now being delivered. The orientation programme provides new staff with relevant information for safe work practice. Staff are required to complete written core competencies during their induction. These competencies are repeated annually. There is an implemented annual education and training plan that exceeds eight hours annually. All staff participate in continuing education relevant to physical disability and young people with physical disabilities. There is an attendance register for each training session and an individual staff</p>

		<p>member record of training. Six of twelve RNs have completed their interRAI training with another one currently in progress of completing.</p> <p>In the 2016 calendar year Elloughton cared for nine palliative residents. Since January 2017 year 32 palliative residents have been admitted. Two workshops on Te Ara Whakapiri were held at Elloughton for clinical staff. Elloughton engaged in the South Canterbury Hospice to deliver the Fundamentals of Palliative Care course. Monthly training sessions were well attended. This course is being repeated in 2018. Staff were encouraged to take up this training.</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. There is a full-time facility manager and clinical nurse manager, who work from Monday to Friday.</p> <p>The facility is split into four wings; the Elizabeth, William Grant, Mountain View and Elloughton Grange wings.</p> <p>In the Elizabeth wing, there are 22 residents in total (all hospital level), there is one RN on duty on the morning and afternoon shifts. They are supported by four HCAs (two long and two short shifts) on the morning shift and on the afternoon shift and one HCA on the night shift.</p> <p>In the William Grant wing, there are 23 residents in total (one rest home and 22 hospital level) there is one RN on duty on the morning and afternoon shifts. They are supported by four HCAs (two long and two short shifts) on the morning shift and on the afternoon shift and one HCA on the night shift.</p> <p>In the Mountain View wing, there are 18 residents in total (10 rest home and eight hospital) there is one RN on duty on the morning and afternoon shifts. They are supported by two HCAs (one long and one short shift) on the morning shift and on the afternoon shift and one HCA on the night shift.</p> <p>In the Elloughton Grange wing, there are 14 residents in total (six rest home and eight hospital) there are two HCAs (one long and one short shifts) on the morning shift and on the afternoon shift and one HCA on the night shift. The RN from the Mountain View wing also oversee Elloughton Grange wing.</p> <p>There is one RN on night shift for the facility.</p> <p>Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed report there are sufficient staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	FA	<p>The resident files sampled were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are</p>

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		protected from unauthorised access by being held in a locked office. Care plans and notes are legible and where necessary signed (and dated) by a RN.
<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	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager in conjunction with the clinical manager screens all potential residents prior to entry and records all admission enquiries. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	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 using the yellow envelope system. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Registered nurses are responsible for the administration of medications and they complete an annual medication competency and attend medication education annually. Medication prescribed is signed as administered on the pharmacy generated signing chart. The facility uses blister pack medications. The RN on duty reconciles the delivery and documents this on the signing sheet. There were two self-medicating residents on the day of audit. A completed competency assessment was sighted for these residents. Standing orders are not used. Medical practitioners write medication charts correctly and there was evidence of one to three monthly reviews by the GP. All 18 medication charts reviewed had photo identification and allergy status identified.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	FA	An external contractor with an existing relationship with Radius is responsible for the food service at Elloughton Gardens. The contracted provider employs sufficient kitchen staff to provide meal services over seven days a week. There is a rotating four-weekly menu in place that is designed by a dietitian.



A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		<p>Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed.</p> <p>Food safety information and a kitchen manual are available in the kitchen. Food is plated in the main kitchen and transferred to resident dining areas by hot boxes. Food served on the day of audit was hot and well presented.</p> <p>The residents interviewed spoke positively about meals provided and they all stated that they are asked by staff about their food preferences.</p> <p>The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. All food is stored and handled safely. The kitchen is clean and cleaning schedules are adhered to.</p> <p>Kitchen staff have been trained in safe food handling.</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 reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The RN completes an initial assessment and care plan on admission, including a clinical risk assessment and relevant risk assessment tools. Risk assessments are completed six monthly with the interRAI assessment, or earlier due to health changes. InterRAI assessments reviewed were completed within 21 days of admission for all eight long-term residents. Resident needs and supports were identified through available information such as discharge summaries, medical notes and in consultation with significant others and included in the long-term care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused,</p>	FA	<p>The long-term care plans reviewed, described in detail, the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. From the care plan, the RNs generate a work log for staff to follow. Residents and their family/whānau are involved in the care planning and review process. Six monthly multi-disciplinary meetings are held</p>

integrated, and promote continuity of service delivery.		and provide a forum to discuss health and treatment changes and activity involvement. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the electronic plans easy to follow.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Registered nurses (including the clinical manager) and health care assistants follow the detailed and regularly updated care plans and report progress against the care plan each shift. When a resident's condition changes, the RN initiates a GP, NP or nurse specialist consultation or referral, for example to the dietitian. If external medical advice is required, this will be actioned by the GP.</p> <p>Staff have access to sufficient medical supplies (e.g., dressings). 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>Wound assessment, monitoring and wound management plans are in place for fourteen skin tears, five surgical wounds, two ulcers, and 17 skin conditions, all of which demonstrated that appropriate cares were documented and implemented. There was one pressure injury (community acquired) on the day of audit. The service is proactive about wound management. There is wound nurse specialist involvement in the management of the pressure injury.</p> <p>Care plan interventions include monitoring charts including repositioning, and food and fluid charts demonstrate interventions to meet residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	CI	<p>An activities coordinator with one year in the present role is employed fulltime with support from a part time assistant, two days per week. The team has access to regional DT networks, support from the facility manager and additional organisational support. The programme is provided in a variety of forms to maintain interest and physical well-being for all groups of residents. The programme is divided into four daily segments. The early morning programme has allocated one-on-one time for hospital residents and for those who choose not to participate in the group activities. Activities and entertainment occur in the main lounge, the conservatory and the smaller lounge. Group activities include (but are not limited to): walking groups, church meetings, baking, newspaper reading, housie, word games, quizzes, board games, bowls, massage therapy, current affairs and arts and crafts. Outings to the library, community events, concerts and local places of interest are planned. Special events are celebrated. Community engagement has included association speakers, exchange letters and visits from local schools and pet therapy visits.</p> <p>Each resident has an individual activities assessment completed on admission and entered into an electronic database. From this information an individual activities plan is developed as part of the care</p>

		<p>plan by the registered nurses with input from the activities staff. All long-term resident files sampled have a recent activity plan within the care plan, and this is evaluated at least six monthly when the care plan is evaluated.</p> <p>Residential disability residents are encouraged and supported to engage in 1:1 and individual activities in the community, such as attending riding for the disabled, swimming and attending social clubs. Some activities are provided specifically for this group in the smaller lounge. An information area in the conservatory displays photos of residents enjoying activities along with information of up and coming events. All residents have access to a weekly planner. A facility newsletter is distributed monthly with news and views and information on future events. Residents and families interviewed commented positively on the activity programme. Residents and families provide feedback on the activities through surveys, resident meetings and the six-monthly MDT reviews.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission. In files reviewed the long-term care plan was evaluated at least six monthly or earlier if there is a change in health status. There is at least a three-monthly review by the GP. All changes in health status are documented and followed up. A RN signs care plan reviews. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files reviewed. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed, and the resident reassessed. Examples of close liaison with dietitians, physiotherapist, mental health staff and social workers were sighted in resident files reviewed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected</p>	FA	<p>Elloughton Gardens has two sluice rooms. Both sluice rooms have a sanitiser and appropriate personal protective equipment available. Both sluice rooms have a keypad lock. Chemicals are safely stored in cleaner's rooms and all chemicals sighted were labelled with the manufacturer's label. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Material data sheets are available for all chemicals.</p>

from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		
<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 has a current building warrant of fitness that expires 1 May 2018. The building has a number of alcoves and lounge areas. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment has been serviced and/or calibrated. Essential contractors are available 24 hours. Hot water temperatures are monitored monthly and are maintained between 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. Residents have access to external areas that have seating and shade. There is an outdoor designated resident smoking area. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Two wings have full ensuite services in each room while the other two have either shared ensuites or toilets only. One room has no ensuite services but is in close proximity to a communal toilet. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are spacious. There is adequate room to safely manoeuvre mobility aids and cater for equipment such as hoists, wheelchairs and fallout chairs and required staff. The doors are wide enough for bed transfer. Residents and families are encouraged to personalise their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment,</p>	FA	<p>There is an open plan communal lounge and dining room in the new building which is large enough to cater for rest home or hospital residents, equipment and carers and/or visitors. Activities can also be provided from this area. Additionally, there is a sun lounge at the end of one wing and a separate</p>

<p>Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>activities room located adjacent to the conservatory.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>An external service is contracted to collect all communal linen daily. Clean linen is returned at the same time and laundry/cleaning staff distribute all clean laundry to linen storage areas. There is a well-appointed laundry with facilities to manage all personal laundry on-site. The laundry has defined dirty/clean areas. The staff interviewed have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility. The cleaners' trolley was well equipped and stored in designated locked rooms when not in use.</p> <p>Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an emergency and disaster management plan in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Elloughton Gardens has an approved fire evacuation plan dated 27 September 2016. Fire evacuation drills occur six monthly, with the last evacuation drill occurring on 23 January 2018. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (BBQ). The service has alternative gas facilities for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup.</p> <p>Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are available. There are civil defence kits in the facility that are checked six monthly. There is sufficient water stored to ensure for three litres per day for three days per resident. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitor's book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night. Access by public is limited to the main entrance.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	FA	<p>Heating is a mix of panel heating and ceiling heating. The facility is well ventilated when required. All rooms have external windows that open allowing plenty of natural sunlight.</p>

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	Radius Elloughton Gardens has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPIs. A registered nurse is the designated infection control nurse with support from the regional clinical manager and the quality management committee (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Radius infection control programme was last reviewed in March 2018.
<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	A registered nurse at Radius Elloughton Gardens is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the quality management team and clinical staff) has good external support from bug control, the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and</p>	FA	There are Radius infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated.

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 policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</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 manual. 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. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually, and is provided to Radius head office. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality meetings and staff meetings and plans and interventions resulting from surveillance create improvements in a way that exceeds the required standard. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the acting facility manager. There has been a respiratory outbreak in August 2016 which was well managed and reported appropriately.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there were five residents using six restraints (bed rails) and there were no residents using an enabler. All necessary documentation is available in relation to the restraints. Staff training has been provided around restraint minimisation in March 2018. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical nurse manager) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>

procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint coordinator in partnership with the RNs, GP, resident and their family/whānau, undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Three residents where restraint was in use (two lap belts and one bed rail), files were reviewed and contained completed assessments. The completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form and reflects the actual times monitoring occurred, evidenced in three resident files where restraint was being used.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly as part of the restraint committee meeting. A review of three resident files identified that evaluations are up-to-date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint minimisation programme is discussed and reviewed at the monthly restraint meetings, attended by the restraint coordinator, RNs and HCAs. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme, and staff education and training. Six monthly internal audits of restraint practices are also completed.</p>



## Specific results for criterion where corrective actions are required

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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The service is proactive around developing corrective action plans when unwanted trends are identified in key performance indicators (KPI). An example is the corrective actions taken around a higher than the KPI falls rate.	In 2016 quality indicator data indicated that falls rates were high and developed a corrective action plan to address this. Interventions were implemented including the falls coordinator and clinical manager meeting and identifying residents requiring individual falls prevention plans and putting these plans in place, relaying the outcomes of this meeting to the registered nurses meeting and at the staff meeting to ensure all staff were vigilant around monitoring at risk residents. These interventions resulted in a steady month by month drop in falls rate. The rate rose slightly early in 2017 and the project was stepped up so that the rate has begun to drop again.
Criterion 1.3.7.1 Activities are planned and	CI	Radius Elloughton has offered an interesting and varied activities programme previously.	The activities team felt they could improve the activities plan, and with resident consultation made alterations to the programme. All residents have specific individual activities developed and documented in an electronic resident management system. The programme is flexible and includes spontaneity and improvisation. It also caters for

provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.		Recent improvements have resulted in an increase in residents' satisfaction for activities.	large groups and smaller groups without disrupting individual activities. Individual activities include craft projects of particular interest to a resident. As a result of these improvements to the programme, satisfaction has improved from 72% of residents being neutral or quite satisfied in the 2017 survey to 78% being very satisfied or quite satisfied in 2018.
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End of the report.