

Radius Residential Care Limited - Althorp

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: Althorp

Services audited: Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

Dates of audit: Start date: 24 July 2019 End date: 25 July 2019

Proposed changes to current services (if any): This audit included verifying the service has suitable to provide dual-purpose (rest home and hospital level) in ten beds in the McLeod wing.

Total beds occupied across all premises included in the audit on the first day of the audit: 96

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Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Radius Althorp is owned and operated by Radius Residential Care Limited. The service provides care for up to 117 residents requiring rest home, hospital, psychogeriatric and dementia level of care. On the day of the audit there were 96 residents.

The service is managed by an interim facility manager/registered nurse who has experience in aged care management. She is supported by a Radius regional manager and a Radius clinical contractor who is currently overseeing clinical care. Residents, relatives and the GP interviewed spoke positively about the recent changes at Althorp.

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, general practitioner and physiotherapist.

This audit also included verifying ten beds in the in the McLeod wing as suitable for rest home level/dual-purpose care.

This certification audit identified areas for improvement around communication with families, complaints management, aspects of incident management, staffing, assessment timeframes, care plans, evaluation, and medication.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Radius Althorp policies are in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights 'the Code' and copies of the code are displayed throughout the facility. There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. There are implemented policies at Althorp to protect residents from discrimination or harassment. There is an open disclosure and interpreter's policy that staff understand. Family/friends can visit at any time and interviews verified ongoing involvement with community activity is supported. There is a complaints policy supporting practice. Staff interviews confirmed an understanding of the complaints process.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Althorp is part of the Radius group and as such, there are organisational-wide processes to monitor performance. Recent changes in management have been supported by Radius support staff, an interim manager, clinical contractor and the regional manager. A

new facility manager has commenced employment and is currently orientating. 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. Residents' meetings are held bi-monthly 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 planned roster that provides appropriate coverage for the effective delivery of care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is an admission pack that provides information on all levels of care. Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. Sufficient information is gained through the initial support plans, specific assessments, discharge summaries, and the care plans to guide staff in the safe delivery of care to residents. The care plans are resident, and goal orientated. Care plans are reviewed every six months or earlier if required. Files reviewed identified integration of allied health and a team approach is evident in the overall resident file. There is a review by the general practitioner at least every three months.

The activities team implements the activity programme to meet the individual needs, preferences and abilities of the resident groups. The programme encourages the maintenance of community links. There are regular entertainers, outings, and celebrations. Activities are focused on meaningful and sensory activities in the dementia care and psychogeriatric units.

Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior healthcare assistants who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner. The psychogeriatrician visits the service fortnightly.

All meals are provided on site by a contracted service. There is a current food control plan in place. Resident dietary needs are met, and alternative foods offered for dislikes. There are nutritious snacks available 24 hours.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan in place. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. Cleaning and laundry services are well monitored through the internal auditing system. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas in each wing. The internal areas are ventilated and heated as needed. The outdoor areas are safe and easily accessible and secure for the wings that require this.

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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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures for the safe assessment and review of restraint and enabler use. During the audit, there were no residents using restraint and two hospital residents voluntarily using enablers. The restraint coordinator reviews enabler use three monthly.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control management system is appropriate for the size and complexity of the service. The infection control coordinator (registered nurse) working together with the clinical team leader, is responsible for coordinating and providing education and training for staff. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff and residents are offered the annual flu vaccine. There have been no outbreaks.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	36	0	5	4	0	0
Criteria	0	84	0	5	4	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 24 care staff, including eleven healthcare assistants (HCA), nine registered nurses (RN), two clinical team leaders and two activities coordinators confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Five residents (two rest home and three hospital) and 12 relatives (three hospital, two dementia and seven psychogeriatric) were interviewed and are aware of the Code. The current management acknowledged this, and a corrective action plan was in place. Staff receive training on the Code, last occurring in October 2018.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need	FA	Twelve resident files were reviewed; (three hospital level of care including one younger person with physical disability, two rest home level of care including one respite care and one palliative level of care resident admitted into a GP bed; two dementia level of care and four psychogeriatric level of care). Informed consent processes are discussed with residents (as appropriate) and families on admission. Written consents are signed by the resident or their enduring power of attorney (EPOA). Advanced directives are signed for separately by the competent resident. There was evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order where residents were deemed not to be competent. The EPOA had been activated in the files reviewed of dementia care and psychogeriatric care residents. The registered nurses and

to make informed choices and give informed consent.		<p>healthcare assistants 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 long-term resident files reviewed had signed admission agreements. The respite care resident had a short-term admission agreement.</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, (eg, attending cafés, and restaurants). Interviews 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</p>	PA Moderate	<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 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 eight complaints made in 2018 as per register and nine received in 2019 year to date. Not all complaints reviewed included follow-up meetings and letters or resolutions within the required timeframes as determined by the Health and Disability Commissioner. One complaint made in May 2019 from a family member remains open pending sign off from the family. The business plan for 2019 to 2020 includes a goal to provide opportunities and take feedback to address issues and concerns professionally to minimise escalation.</p>

upheld.		<p>Two complaints received in 2019 through the district health board (DHB), evidenced comprehensive investigation of issues and development of corrective action plans to meet accepted shortfalls. One of these complaints has been tentatively signed off. The other is ongoing with evidence of ongoing communication with both the DHB and the complainant.</p> <p>Six of seven HDC complaints from 2015 (before Radius purchase) have been signed off as resolved. The outcome of the investigation of the other has been communicated to Radius and corrective actions are being implemented.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service provides information to residents that includes the Code, 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. Not all residents and relatives interviewed identified they were well informed about the Code of Rights (link 1.1.9.1). Bi-monthly resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey was issued in October 2018. A number of corrective actions were implemented as a result.</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>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, residents' privacy and dignity. The 2018 satisfaction survey identified 95% of residents were happy with privacy. Contact details of spiritual/religious advisors are available. Staff education and training on abuse and neglect has been provided, last occurring in October 2018.</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</p>	FA	<p>Althorp 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 seven residents who identified as Māori. Four Maori resident files were reviewed and included a Māori health plan. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Māori consultation is available through Huria Kaumātua Care. A Hauora hui was held on 7 December 2018.</p>

respects and acknowledges their individual and cultural, values and beliefs.		
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/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 2018 satisfaction survey identified 82% outcome for cultural/spiritual needs being met. A corrective action related to this has been implemented.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. The staff/quality meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the interim facility manager, clinical contractor, clinical team leaders and RNs confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>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. Not all residents and relatives interviewed spoke positively about the care and support provided, however noted recent improvements. Staff had a sound understanding of principles of aged care and stated that they feel supported by the recent input from the regional manager, interim facility manager, clinical contractor, clinical team leaders and nursing staff. There are implemented competencies for HCAs and RNs. There are clear ethical and professional standards and</p>

		boundaries within job descriptions.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Moderate	<p>Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Not all family members interviewed stated they are informed of changes in the health status of residents and not all incident forms sampled evidenced residents were informed of adverse events. Resident/relative meetings are held bi-monthly. The interim facility manager and clinical contractor 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.</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 Althorp is part of the Radius Residential Care Group. The service currently provides rest home, hospital and dementia and psychogeriatric level care for up to 117 residents. On the day of the audit there were 96 residents. There were six rest home (including one respite resident and one end of life resident), 36 hospital residents (including one end of life in the GP funded beds, and one younger person with a disability (YPD) contract), 15 residents in the dementia unit and 39 residents across the PG units. The service also has five GP funded beds and one funded respite bed. All other residents were under the age-related residential care (ARRC) contract.</p> <p>This audit also included verifying the service has suitable to provide dual-purpose level care across 10 rooms in their hospital (McLeod wing). The wing is appropriate for providing rest home level care. Noting the service was only certified for rest home- dementia level care.</p> <p>The Radius Althorp business plan 1 April 2019 to 31 March 2020 is linked to the Radius Residential Care Group strategies and business plan targets. The mission statement is included in information given to new residents. An organisational chart is in place. Quarterly reviews are undertaken to report on achievements towards meeting business goals.</p> <p>A new facility manager has been in the role for two days and was present and observing during the audit and will commence at Althorp on the 12 August 2019. Support will continue to be provided by the interim FM for up to two months along with the Radius clinical contractor (RN). The clinical nurse manager is on leave and the clinical contractor is providing on site cover. She is supported by the regional manager (RN). The current management team includes an interim facility manager.</p> <p>The interim facility manager (has been in the role for seven weeks and previous roving manager with a background in dementia care) and radius clinical contractor (RN with 6 years' experience with radius and previous experience in aged care)have maintained more than eight hours of professional development activities related to managing an</p>

		<p>aged care facility. The new manager is day 2 of her employment and is a mental health nurse with a background in dementia education)</p> <p>The interim facility manager and radius clinical contractor have maintained more than eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the facility manager, the clinical contractor is in charge with support from the regional manager and clinical team leaders.</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>The organisational business plan includes quality goals and risk management plans for April 2018 to 2019. The quality plan for April 2019 to March 2020 is under review following recent management changes. Goals and risk management for the current year were sighted post audit and included a focus on maintaining the EPEC philosophy and re-establishing and building on community relationships. Further goals around staffing and staff development include (but not limited to), manage roster against occupancy with appropriately orientated and trained staff and a focus on upskilling registered nurses and care staff. Quality and risk performance is reported across facility meetings and to the regional manager. The interim facility manager advised that she is responsible for providing oversight of the quality programme. There are monthly staff/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 bi-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 October 2018 was at 96%. A corrective action plan was developed and completed in January 2019 around communication, cleaning, laundry, the activities programme and staffing. There is evidence most actions have been recently signed as completed and actions are continuing.</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</p>

		<p>relating to the Health and Disability Services (Safety) Act 2001. The Radius 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 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>Restraint and enabler use is reviewed at the monthly staff/quality meeting. Health and safety policies are implemented and monitored by the health and safety committee. The health and safety representative (office manager) interviewed confirmed their understanding of health and safety processes. She has completed external health and safety stage three training. Risk management, hazard control and emergency policies and procedures are in place. Hazard identification forms and an up-to-date hazard register (last reviewed at the June 2019 meeting) 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.</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>	PA Low	<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 the monthly staff/quality meetings. A review of sixteen incident/accident forms from July 2019 identified that not all forms include review by a RN at the time of the incident. Neurological observations were implemented for eight reviewed unwitnessed falls or suspected injury to the head but did not always follow policy (link 1.3.6.1).</p> <p>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. Section 31 notifications made since the last audit include two stage three pressure injuries, a shortage of registered nurses, an unexpected death, physical aggression by a resident and attempted suicide. Coroner's notifications were made regarding an unexpected death and death following a fall. The coroner's investigations are still open.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Twelve staff files reviewed (two clinical team leaders, two RNs, four HCAs, one activities coordinator, one cleaner, one maintenance and one cook) 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. The orientation programme provides new staff</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>with relevant information for safe work practice.</p> <p>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. There is an attendance register for each training session and an individual staff member record of training. Seven of twelve RNs have completed their interRAI training with another three currently in progress of completing. Registered nurses are supported to maintain their professional competency.</p> <p>Radius contracts NZQA training to the NZ tertiary institute. Dementia standard training is a requirement for all staff working in the dementia unit. Radius encourages and supports staff to achieve qualification.</p> <p>There are 54 HCAs who work in the dementia unit. Twenty-one HCAs have completed the dementia standards and 33 HCAs are in progress of completing. A corrective action plan is in place to ensure all staff working in the dementia units attains required qualifications. Five of the HCAs in the progress of completing the training have been employed in the unit for over two years and have completed their assessments.</p> <p>The service has responded to recent complaints, survey results and corrective actions plans by implementing a number of toolbox talks and sessions by mental health services for the older person. Training has been focused on person-centred care and communication.</p> <p>The service and the DHB have worked together to identify suitable facility and clinical leadership including the appointment of the new facility manager. Radius have appointed an experienced interim manager and a clinical contractor to review staff competencies, skill levels, education and behaviours. Where skill and competency shortfalls have been identified, a support plan was established at both an organisational and individual level. The DHB have been updated on progress at regular meetings.</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>	<p>PA Low</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The clinical contractor and clinical team leaders are registered nurses (RNs) and share the on call. There is one clinical team leader responsible for the hospital units and another for the psychogeriatric units. A minimum of three RNs is rostered on duty 24 hours a day, seven days a week.</p> <p>The service is divided into six separate units (three psychogeriatric units, one secure dementia and two hospital/rest home units). Staff turnover has been moderately high, and it has not always been possible to cover all shifts as rostered. Staff and family report staff shortages at times.</p> <p>At least one RN is rostered in each of the hospital units (Rueben unit includes 14 hospital and three rest home residents and McLeod unit includes 25 hospital and three rest home residents), on morning and afternoon shifts. Night shift is covered by one RN across the two hospital units. In each of the hospital units on morning shift there are two HCAs on long shifts. In Rueben there are two short shift HCAs with provision for a third if necessary. In McLeod, three staff are rostered short morning shifts. On the afternoon shift in Rueben there are two long shifts and</p>

		<p>one short shift rostered. In McLeod, there are two long shifts, and two short shifts, with a third three-hour shift. There are four HCAs covering both hospital units on night shift.</p> <p>The psychogeriatric units (Best and Scott) have 12 residents each and Munro unit has 14 residents. There are two RNs across the three units on morning shifts, afternoon and night shift. Best and Scott units have HCAs working four long shifts and two short shifts on mornings and two long and two short shifts in the afternoon. There is one short float HCA shift rostered on afternoon shift. Munro unit has two HCA long shifts and one short shift on morning, one long and one short on afternoons with an afternoon shift float shift working between Munro and Church and two HCAs at night shift.</p> <p>The dementia rest home unit (Church) has 13 residents. The 15-bed secure dementia unit (Church unit) has two HCA long shifts and one short shift on morning, one long and one short on afternoons and one HCA on night shift. The unit is supported by one of the RNs in the PG unit.</p> <p>Residents, family and the GP expressed concern regarding staffing and the layout of the facility. The roster evidenced expected staffing standards and the DHB contracts are met. In discussion with the management team there is an undertaking to review staffing utilisation and staffing levels. Staff and relatives reported there was good access to a RN at all times.</p> <p>The secure dementia unit (Church unit) has 13 residents has one HCA long shift and one short shift on morning, one long and one short on afternoons and two HCAs on night shift. The unit is supported by the RN in Munroe. The clinical team leader also provides RN support as required.</p> <p>The roster is able to be changed in response to resident acuity.</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 electronic 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 electronic files require authorised login and password access. Paper-based files are protected from unauthorised access by being held in a locked office.</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>The service has admission policies and processes in place. Referring agencies establish the appropriate level of care required prior to admission of a resident. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service, including admission into the dementia care or psychogeriatric care units. The clinical contractor screens all potential residents prior to entry and records all admission enquires.</p> <p>The admission agreement form in use aligns with the requirements of the ARC and ARHSS 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. Residents and families interviewed verified they received information prior to admission and had the opportunity to discuss the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. Residents who require admission to hospital or transfer are managed appropriately and relevant information is communicated to the receiving health provider or service. Two staff accompany the transfer of psychogeriatric or dementia level of care resident's to hospital. A computer-generated transfer form and supporting documentation accompanies residents to the receiving facility and communication with family is documented.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>There are comprehensive policies and procedures in place for all aspects of medication management. There were no residents self-administering on the day of audit. There are two medication rooms in the hospital section, one in each wing and both have secure keypad access. There are medication rooms in each unit (one dementia and three psychogeriatric). Medication fridges had daily temperatures checks recorded and were within normal ranges. Registered nurses or senior HCAs administer medications who have completed their annual competency assessment. There is a signed agreement with the local pharmacy. The facility uses a robotics pack medication management system for the packaging of all tablets. There was no documented evidence that other medications, including robotic packages received are checked and recorded. The facility does have standing orders. Eyedrops and other liquid medications were dated on opening.</p> <p>The facility utilises a paper-based medication management system. Twenty-four medication profiles were reviewed (eight psychogeriatric, four dementia and ten hospital and two rest home care). All charts reviewed had photo identification and allergy status documented. All medication sheets evidenced three monthly reviews by the GP. Prescribed medication is signed after being administered as witnessed on the day of the audit. All 'as required' medication prescribed had indications for use documented by the GP. Effectiveness of 'as required' medication</p>

		administered was documented in the progress notes.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals are prepared on-site by a contracted food service. The kitchen manager/chef is supported by two cooks and a kitchenhand on duty daily. The four weekly winter and summer menu has been reviewed by a dietitian. The menu can be changed to meet the resident preferences. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed as part of the care plan review and the kitchen is notified of any change in dietary requirements. Pureed meals are provided and presented moulded shapes (sighted). Resident dislikes are accommodated. Lip plates are provided to encourage resident independence with eating. Meals are plated in the kitchen and transported in hot boxes to each unit kitchenette. 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 and home-baking readily available for the dementia care and psychogeriatric residents.</p> <p>The food control plan has been verified for two years and expires 3 February 2020. All kitchen staff have completed food safety training. The temperatures of refrigerators, freezers, chiller, incoming chilled goods and end cooked food and meat temperatures are taken and recorded on the food service app. All food is stored appropriately, and date labelled. Cleaning schedules are maintained.</p> <p>Residents and relatives have the opportunity to feedback on the service through meetings and surveys. Residents and the family members interviewed were very happy with the quality and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau and referring agency. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Anyone declined entry would be 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>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative (as appropriate). InterRAI assessments were completed in all long-term resident files reviewed. An initial nursing assessment and an interim care plan is completed (link 1.3.3.3). Personal needs, outcomes and goals of residents are identified. Resident files reviewed demonstrated that a range of assessment tools were completed in resident files and reviewed at least six monthly including (but not limited to); falls, pressure areas and continence. All files reviewed for residents under the ARHSS and ARCC contracts had a current interRAI assessment. Vital signs and weights were monitored on a weekly to monthly basis dependant on needs. Assessments are conducted in an appropriate and private manner. Behaviour assessments had been completed for the dementia care and psychogeriatric files reviewed. The outcomes of assessments formed the basis of the log-term care plans.</p> <p>Assessment process and the outcomes are communicated to staff at shift handovers through verbal and written shift reports, communication books, progress notes and care plans. Residents (rest home and hospital) and family interviews stated they were involved in the assessment process on admission and ongoing.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Ten long-term resident care plans were reviewed on the electronic resident management system. The respite care resident (rest home) and palliative care resident in GP bed were not required to have long-term care plans. The one respite resident file reviewed included assessments and a short stay care plan. Long-term care plans reviewed recorded the resident's problem/need and objectives/interventions to support resident needs and goals, however not all long-term care plans had documented interventions that reflected the residents' current needs and goals. A care plan summary for each resident provides a guide for HCAs to follow. Staff interviewed reported they found the plans easy to follow.</p> <p>There were behaviour management plans in the files of the dementia care and psychogeriatric residents that reflected the outcomes of behaviour assessments. Behaviour management plans included triggers, behaviours and interventions including de-escalation strategies such as one-on-one time and activities. One behaviour management plan had not been updated with recent behaviours.</p> <p>Resident files demonstrated service integration and evidence of allied health care professionals involved in the care of the resident such as mental health services for the older person team, podiatrist and physiotherapist.</p> <p>Residents (as appropriate) and their family/whānau confirmed they were involved in the care planning process as evidenced in the family contact form. Short-term care plans reviewed were in use for changes in health status. Short-term care plans were reviewed and resolved or added to the long-term care plan if an ongoing problem.</p>
<p>Standard 1.3.6: Service</p>	PA Moderate	<p>Clinical team leaders, registered nurses (RNs), and healthcare assistants follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the wound care nurse specialist or the mental health team). If external medical advice is required, this will be</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>actioned by the GP. The GP had not been notified of three residents with weight loss.</p> <p>Sufficient continence products are available and resident files reviewed included a continence assessment and plan as part of the plan of care. Specialist continence advice is available through the DHB as needed and this could be described.</p> <p>Staff have access to sufficient medical supplies (eg, dressings). Wound assessment, wound management and evaluation forms are in place for five hospital residents, two dementia care residents and four psychogeriatric residents with wounds (including one surgical wound and one stage two facility acquired pressure injury). Wound management, monitoring, photos and short-term care plans were in place for wounds which had been reviewed as per the planned frequency. All have appropriate care documented and provided, including pressure relieving equipment. Access to specialist advice and support is available as needed.</p> <p>Interviews with registered nurses and HCAs demonstrated understanding of the individualised needs of residents. Monotiling forms reviewed included two hourly turning charts, monthly weight and vital sign monitoring, food and fluid charts, behaviour charts and daily activity check lists, however neurological observations had not been fully completed for unwitnessed falls.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Rest home and hospital:</p> <p>A diversional therapist (DT) leads the activities team, which includes three activities coordinators. All members of the activity's teamwork 30 hours per week and provide programmes in different units from Monday to Friday. Two activities coordinators cover the hospital section, one in McLeod wing and the other in Reuben wing. The activities team meet every Monday morning with the facility manager to discuss their programme, important events and review action plans to address activity related concerns. The activities programme template is designed for high end and low-end cognitive functions and meets individual cognitive, intellectual and physical needs. Activities include (but are not limited to) arts, crafts, music, baking, exercises and board games. Community links are maintained with visiting church groups, outings to places of interest and picnics. The activities team facilitate combined programmes for important events and entertainment sessions. The programme is developed monthly and displayed in large print in all units, common areas and in all resident rooms. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. Each resident has an individual activities assessment on admission and from this information an individual activities plan is developed as part of the care plan by the activities staff. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan.</p> <p>Dementia care and psychogeriatric level of care:</p> <p>There are two activity coordinators (one DT and one level four HCA that has completed the dementia units) who cover two units each from 9.30 am to 4 pm Monday to Friday. Each unit has an activity area where residents and staff can freely access resources for small group or one-on-one activities. Activities are part of the HCA role and</p>

		<p>HCA's were observed in activities on the days of audit. Each unit (one dementia care and three psychogeriatric units) have separate activity programmes which focus on meaningful and sensory activities. There are monthly themes and activities. Dementia unit residents can choose to be involved/participate in the crossword club, exercise group, carpet bowls, table activities, walking group, reminiscing, coffee club, cooking club, men's woodwork group, art and craft and musical activities. Activities offered in the three psychogeriatric units include music, reminiscing, sing-a-longs, colouring art, exercises, men's group, ladies flower arranging, games/crossword, one-on-one pampering, cooking and newspaper reading. There are supervised combined unit activities and entertainment in the large recreational room. Happy hours are held regularly. There are weekly outings/scenic drives for all residents. The activity coordinators and DT have current first aid certificates. The activity team is being mentored by a Radius contracted manager/educator experienced in dementia care to implement goals/strategies around de-escalation/re-direction of behaviours. Memory boxes have been introduced in consultation with families which have items/memorabilia that are meaningful to the resident and assist staff in prompting discussion or distraction from behaviours. The memory boxes are kept in the resident's room along with an "all about me" quick reference guide for staff.</p> <p>All residents have an activity assessment completed on admission and have an individual leisure plan and social activity chart on the electronic resident management system. Leisure plans are evaluated six monthly. Residents (as appropriate) and family members can provide feedback on the programme through resident meetings and surveys. Residents and relatives interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>The registered nurses evaluate initial care plans within three weeks of admission. The long-term care plan has been evaluated six monthly for all long-term residents with the exception of two psychogeriatric residents. Case conference checklists are signed by those present including the GP at the three-monthly review. The family contact forms reviewed in the rest home/hospital wings reflect that family are invited to attend multidisciplinary team (MDT) reviews and informed on GP reviews. There was no documented evidence of family notification or involvement in the evaluation of care plans for two of four psychogeriatric files and one dementia care resident file. The care plan evaluations that have been completed, document if the resident goals have been met or unmet.</p> <p>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 (link 1.3.5.2). The family contact forms reviewed in the rest home/hospital wings reflect that family are invited to attend multidisciplinary reviews and informed on GP reviews.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referral through the clinical team leaders and specialist referrals are made through the GP. The clinical</p>

<p>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>team leaders and registered nurses interviewed provided examples of where a resident's condition had changed, and the resident was reassessed. There was evidence of where a resident's condition had changed, and the resident was reassessed for a higher or different level of care from hospital to psychogeriatric level of care and from dementia respite to dementia level of care. Discussion with the clinical team leaders identified that the service has access to a wide range of support either through the GP, DHB specialists and contracted allied services.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Sharps containers are available and meet the hazardous substances regulations for containers. Chemicals sighted were clearly labelled with manufacturer's labels and stored safely throughout the facility. Safety datasheets were available. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. A hazard register was evident that identified hazardous substances. Staff interviewed indicated a clear understanding of processes and protocols.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	FA	<p>The building has a current building warrant of fitness that expires on 22 November 2019. The facility is in two buildings, one hospital which has three wings and a dementia/psychogeriatric section comprising of four 15-bed wings.</p> <p>The building has a number of alcoves, lounge and dining areas in each wing. There is a full-time property and maintenance manager and a part-time maintenance person employed to address the reactive and planned maintenance programme. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. All ensuite, showers and utility areas had non-slip vinyl flooring. The facility has sufficient space for residents to mobilise using mobility aids and residents were observed moving around freely. The external area is well</p>

for their purpose.		<p>maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>Medical and electrical equipment including hoists and electric beds were recently serviced, however it was noted that four syringe drivers required servicing. Following the draft report the provider advised that syringe drivers completed calibration within four working days following the audit.</p> <p>On the day of the audit it was observed that two call bells were not working, this was escalated to the call bell company as an urgent repair request. Medical and electrical testing of equipment is carried out by an approved contractor as per the planned maintenance programme. A weekly call bell checking system was implemented on July 24 to cover all wings within Radius Althorp. This complements the routine visual checks by all staff when they leave a room after care delivery/ interventions, the six-monthly internal audit process for building and environmental check and the Care and Hygiene Needs audit. Call bell system is a nominated check in these audit.</p> <p>The service is in the process of certifying ten beds in the McLeod hospital wing as suitable for dual purpose hospital of rest home level care.</p> <p>The dementia unit and each psychogeriatric unit has safe access to an outdoor courtyard and gardens which provide seating and shade.</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>All rooms in the hospital/rest home facility have full ensuites large enough to cater for hospital level residents and the associated equipment and staff. There are communal toilets near each lounge. There is a mix of shared ensuites and communal toilet/showering facilities in the dementia unit and psychogeriatric units. Communal toilets are clearly labelled and have privacy systems in place. Fixtures, fittings and toilets/showers are constructed for ease of cleaning. Residents (as appropriate) interviewed, confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed</p>	FA	<p>All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids, including those required by hospital level care residents. Resident bedroom doors in the dementia</p>

Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		unit and psychogeriatric unit have meaningful photos on doors to assist residents to find their rooms. Residents are encouraged to personalise their bedrooms as viewed on the day of the audit.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Rest home and hospital: The communal areas include the open plan main lounge/dining area (with a kitchenette in the hospital wings) and several smaller lounges and family rooms in each wing. The lounge/dining areas are large enough to cater for activities. Seating and space can be arranged to allow both individual and group activities to occur as observed on the days of the audit. The communal areas are easily and safely accessible for residents and visitors who would prefer a quieter activity or space. Dementia and psychogeriatric units: Each unit is spacious with a central observation area and seating and activity tables. There is a kitchenette and dining area with separate lounge and family room for visitors or quieter activities. Each unit has an activity resource area which is readily available to residents. There is a large recreational room in the main corridor that is used for combined activities, entertainment and church services. There is a kitchenette used for morning and afternoon teas, baking activities and there is access to a safe outdoor area.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The facility has a dedicated team of cleaning staff who have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Cleaning trolleys are stored in a locked room when not in use. Safety data sheets were available. Residents and family members interviewed were satisfied with the standard of cleanliness in the facility. All laundry is undertaken on-site by dedicated laundry staff. The laundry is spacious and well organised and divided into a 'dirty and clean' area. Laundry staff member interviewed described appropriate systems for managing infectious laundry. Safety data sheets were sighted in the laundry. All chemicals were stored in a locked cupboard. Residents and relatives interviewed were satisfied with the laundry service.
Standard 1.4.7: Essential,	FA	There is an emergency health 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

<p>Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>staff member on every shift. Radius Althorp has an approved fire evacuation plan dated 16 November 2000. Fire evacuation drills occur six monthly with the last evacuation drill occurring on 13 June 2018. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (BBQ). The service has 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 (water tank) stored to ensure for four litres per day for four 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. The service has a visitors' book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and all resident rooms are appropriately heated and ventilated. Documentation and visual inspection evidences that the environment is maintained at a safe and comfortable temperature. The residents and family interviewed confirmed temperatures were comfortable. All rooms have external windows that open, allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the</p>	FA	<p>Radius Althorp 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 has been newly appointed as the designated infection control nurse with support from the clinical team leader and the quality management committee (infection control team). The infection control nurse has a signed job description. Minutes of the monthly infection control meeting are available for staff. Audits that have been conducted include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Radius infection control programme is linked into the quality management system and reviewed annually.</p> <p>Influenza vaccines are offered to residents and staff annually. Visitors and family are advised not to visit if they are unwell. There have been no outbreaks at the facility since the last audit.</p>

size and scope of the service.		
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse at Radius Althorp is the designated infection control (IC) nurse and has been in the role for two weeks. She is booked to attend infection control training, however in the interim she is working under the supervision of the clinical team leader who has a certificate in infection prevention and control. 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, kitchen, laundry and care staff) have good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities and alcohol hand gel are available in the facility.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are Radius Althorp infection control policies and procedures appropriate 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 annually.</p>

<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 been booked to attend external infection control training. Policies and procedures regarding infection control are available to all staff.</p> <p>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 the Radius Althorp infection control manual. An individual resident infection report is completed for all infections which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used for residents diagnosed with infections as evidenced in the resident files reviewed. Surveillance of all infections is entered onto a monthly infection summary. The infection control officer provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Areas for improvement are identified, corrective actions developed and followed up. This data is monitored and evaluated monthly and annually and provided to Radius head office. If there is an emergent issue, it is acted upon in a timely manner.</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. The restraint coordinator is the clinical team leader for the dementia and psychogeriatric units. There are policies and procedures in place that align with the restraint minimisation and safe practice standards and include the definition for enablers and restraints. The use of restraint is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked. There were no restraints on the day of audit and two hospital level residents using enablers. There was documented evidence of voluntary use of enablers. Enablers are reviewed three monthly. Staff receive training and education around restraint, enablers and challenging behaviours at orientation and ongoing as part of the training plan.</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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	<p>PA</p> <p>Moderate</p>	<p>A complaints and compliments register is maintained on an electronic database, however not all complaints evidenced have been lodged on the database. Policy and procedure includes commitment to meeting actions and timeframes as determined by the Health and Disability Commissioner, however this is not always evidenced as occurring.</p>	<p>i) The complaints register does not include all complaints reported prior to June 2019. Five complaints confirmed in four relative interviews were not on the register.</p> <p>ii) Family interviewed stated three complaints raised in early 2019 were not resolved.</p>	<p>i) Ensure all complaints are added to the complaints register.</p> <p>ii) Ensure all complaints evidence investigation and resolution within required timeframes as determined by the Health and Disability Commissioner.</p>

				60 days
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	<p>PA Moderate</p>	<p>Radius policy includes informing family of adverse events, however not all adverse event forms or progress notes evidenced family were informed. Not all residents interviewed were happy with previous communication, however noted marked improvement in recent weeks. Current management are aware and implementing changes as evidenced on corrective action plans sighted.</p>	<p>i) Six of sixteen adverse events were not evidenced as communicated to family or next of kin.</p> <p>ii) On interview three relatives raised concerns with communication of adverse events, communication of planned family meetings and awareness of who they could talk to about concerns.</p>	<p>i) Ensure family/whānau are advised of adverse events.</p> <p>ii) Ensure family meetings and contact options are communicated to family.</p> <p>60 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Low</p>	<p>Radius policy clearly identifies that all incidents and accidents are reviewed by an RN and actions documented on the designated electronic form. However not all incidents included documentation of the RN actions and not all incidents. Opportunities for minimisation of risk are evidenced and implemented within risk assessments and care plan on an individual basis and at monthly Quality and Risk meetings.</p>	<p>Five of sixteen adverse event forms did not evidence documentation of RN actions at the time of the review.</p>	<p>Ensure all adverse events document RN actions at the time of review.</p> <p>90 days</p>

<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>The current roster evidenced sufficient staff to meet the needs of dementia, psychogeriatric, hospital and rest home level of care residents. The acting facility manager and regional manager have recently reviewed rosters and staffing on night shift has been increased. Staff reported they feel supported by the current management team. The current management team are addressing the staffing shortfalls. A number of new staff have been hired recently and plans are in place to meet the shortfall.</p> <p>There is evidence that not all unexpected leave has been replaced in the past and on interview staff and family reported staff shortages. Rosters evidenced from mid -July onwards have shown that all shifts are filled either through EMPROVO app whereby staff can uplift the shift electronically through the app or with staff agreeing when requested to work the shift or extra hours. The company has recently introduced a system called emprovo which links with time target and sends out texts to all available staff to cover unfilled shifts. On the week of audit all unfilled shifts were covered. Previous weeks show gaps of between five to ten shifts across the facility where staff or agency were unable to cover. Extensive recruitment, hiring of new staff and increased shift allocations are now providing sufficient cover.</p>	<p>There is evidence in previous weeks that not all unexpected leave has been replaced and on interview, staff and family reported staff shortages. However, on the week of audit all unfilled shifts were covered. Previous weeks show gaps of between five to ten shifts across the facility where staff or agency were unable to cover. Extensive recruitment, hiring of new staff and increased shift allocations are now providing sufficient cover</p>	<p>Ensure all shifts continue to be covered as rostered</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and</p>	PA Low	<p>Medication administration practice complied with the medication management policy for the medication rounds sighted. Controlled drugs are checked and recorded on arrival from pharmacy, however there was no documented evidence that other medications received is recorded and checked against the medication chart.</p>	<p>There was no documented evidence of medication reconciliation against the medication charts when robotic packages are delivered from pharmacy.</p>	<p>Ensure all medication when delivered from pharmacy is checked against the prescription and recorded.</p>

appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.				30 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	All resident files reviewed had current interRAI assessments that were completed with required timeframes, however not all nursing documentation was completed within expected timeframes.	<p>(i) One rest home resident did not have initial assessment and interim care plan completed within 24 hours of admission.</p> <p>(ii) Two hospital level residents did not have a long-term care plan completed following interRAI assessments.</p>	<p>(i) Ensure initial assessments and care plans are completed within 24 hours of admission.</p> <p>(ii) Ensure long-term residents have long-term care plans completed following completion of interRAI assessments.</p> <p>180 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe</p>	PA Moderate	Assessments assist in developing care plan interventions. The long-term care plans that were developed in consultation with the resident/relative had been evidenced in the family contact forms.	(i) There were no documented interventions for weight loss for one hospital resident. The same resident did not have the care plan updated to reflect current falls risk and falls	(i)-(iv) Ensure care plans reflect the resident's

the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.		Long-term care plans for two hospital residents, one dementia care resident and one psychogeriatric had not been updated to reflect the resident current needs and interventions to safely guide staff in the delivery of care.	prevention strategies, (ii) another hospital resident recognised as high falls risk did not have their long-term care plan updated to reflect their falls risk, (iii) the behaviour plan for one dementia care resident had not been updated to reflect behaviours as per GP notes. The same resident's pain management plan did not identify the type of pain and location of pain as identified on assessment and (iv) the care plan for one psychogeriatric resident had not been updated following return from hospital to reflect changes in needs and pain management.	current identified needs and supports. 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Interviews with registered nurses, the clinical manager and team leaders demonstrated an understanding of the assessment, monitoring and management plans. Monitoring forms are used to monitor residents' health and well-being including blood pressure and pulse, weight, blood sugar levels, behaviour, food and fluid intake, however not all neurological observations for unwitnessed falls had been completed. Short-term care plans sighted on the day of audit included wounds and skin tear, weight loss and urinary tract infection. These had been reviewed regularly and signed off when resolved or transferred to the long-term care plan.	(i) Five incidents of residents with unwitnessed falls did not have neurological observations completed as per policy. (ii) The GP had not been informed about weight loss for two hospital level residents and one dementia care resident.	(i) Ensure neurological observations are completed for unwitnessed falls as per policy. (ii) Ensure the GP is informed about resident's weight loss. 90 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused,	PA Low	The case conference checklist records those present for the care plan evaluation. The long-term care plan has been evaluated six monthly for all long-term residents with the exception of two psychogeriatric residents. Family are invited to attend and if unable	(i) There were no written care plan evaluations to evidence progress to meeting goals for two psychogeriatric residents and (ii) there was no documented evidence the family were involved in the multidisciplinary (case conference)	(i) Ensure there are written care plan evaluations

indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.		to attend they are informed of any changes to care, however there is no documented evidence of family attendance/communication for three resident files (two psychogeriatric and one dementia).	review for two psychogeriatric residents and one dementia care resident.	completed prior to six monthly review of care plans and (ii) ensure there is documented evidence the family have been involved in the care plan evaluation. 90 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.