

Radius Residential Care Limited - Radius Windsor Court Rest Home

Introduction

This report records the results of a Surveillance 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 Windsor Court Rest Home	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 11 February 2020	End date: 12 February 2020
Proposed changes to current services (if any):		
Total beds occupied across all premises included in the audit on the first day of the audit:	65	

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 Windsor Court is owned and operated by Radius Residential Care Limited. The service provides care for up to 76 residents requiring rest home, hospital or dementia level care. On the day of the audit, there were 65 residents. The facility manager was previously a registered nurse. She has 14 years of experience in rehabilitation management. A team of radius regional managers and a clinical manager support her. Residents and relatives interviewed spoke positively about the services provided.

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

The residents, relatives and nurse practitioner spoke highly of the care and service provided.

The one shortfall from the previous certification audit around staff education remains.

This surveillance audit identified that improvements are required in relation to managing quality data, corrective action plans, timely interRAI assessments, and care interventions.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is established.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Education and training sessions are available for staff to attend.

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

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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The registered nurses' complete assessments, care plans and evaluations using the eCase electronic system. Residents/relatives are involved in planning and evaluating care. Risk assessment tools including the interRAI assessment tool, and monitoring forms are included on this system and are used to assess the level of risk and support required for residents. Service delivery plans demonstrate service integration. Short-term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated.

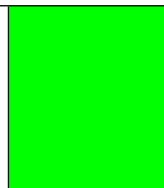
The activities team provide an activities programme that involves the wider community. Each resident has an individualised plan and activities are scheduled across the week.

The medication management system follows recognised standards and guidelines for safe medicine management practice. Staff complete competency assessments.

Meals are prepared on site by a contracted company. Individual and special dietary needs are catered for. Residents interviewed responded favourably regarding the food that was provided.

Safe and appropriate environment

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

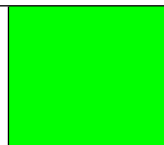


Standards applicable to this service fully attained.

The building holds a current warrant of fitness. Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available.

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.

There were two residents using enablers and one resident using a restraint at the time of the audit. The clinical manager is the restraint coordinator. She is responsible for ensuring restraint minimisation policies and procedures are adhered to, and restraint education if provided for staff.

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.

Standardised definitions are used for the identification and classification of infection events. The infection control coordinator (clinical manager) is responsible for the collation, analysis and trending of data. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	12	0	3	2	0	0
Criteria	0	36	0	4	2	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The service has a complaints policy that describes the management of complaints process. There are complaint forms available throughout the facility. Information about complaints is provided on admission. Interviews with four residents (three rest home, one hospital) and relatives demonstrated their understanding of the complaints process. All staff interviewed five healthcare assistants (HCAs), two registered nurses (RNs), one cook, two activities staff and one maintenance staff) were able to describe the process around reporting complaints. There is a complaints' register that is held in an electronic format.</p> <p>There were 19 complaints lodged in 2019 and 10 in 2020 (year to date). All complaints reviewed had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents and relatives confirmed that any issues they may have are addressed, and that they feel comfortable to raise any concerns.</p>
Standard 1.1.9: Communication Service providers communicate effectively with	FA	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 10 accidents/incidents reviewed met this requirement. Four family members interviewed (two dementia, one rest home, one hospital) confirmed they are kept informed. They are notified following a change of health status of their family member or following an incident/accident. There is an interpreter policy in place and contact details of interpreters were</p>

consumers and provide an environment conducive to effective communication.		available.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Radius Windsor Court is a Radius aged care facility located in the rural town of Ohaupo. The facility is certified to provide rest home, hospital (medical and geriatric) and dementia care for up to 76 residents. There are 20 dementia beds and eight dedicated rest home beds. The remaining 48 beds are dual-purpose. On the day of the audit there were 25 rest home level residents, 22 hospital level residents and 18 dementia level residents. One resident was on respite (dementia level). The remaining residents were on the age-related residential care services agreement (ARCC).</p> <p>The 2019 - 2020 business plan describes the vision, values and objectives of Radius Windsor Court. Annual goals are linked to the business plan and reflect regular reviews via regular meetings and monthly reports to the regional manager.</p> <p>The facility manager was appointed on 18 March 2019. She has fourteen years of experience in management roles in home and community services. She trained as a registered nurse, but has not kept her practising certificate current. This is her first role as a facility manager in an aged care environment. She is supported by a clinical manager/RN who has many years of aged care experience and has been in her current role for six months.</p> <p>The facility manager has maintained at least eight hours of professional development activities related to managing an aged care facility.</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>	PA Low	<p>A quality and risk management system is established with work underway to embed these systems into practice. Discussions with five managers (facility manager, clinical manager, regional manager, roving facility manager, eCase manager) and staff reflected their involvement in quality and risk management processes.</p> <p>Two resident/family meetings occurred in 2019. Minutes are maintained. Satisfaction surveys are scheduled annually but results were not evidenced as being communicated to staff.</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. Policies are reviewed at a national level every two years with input from the facility managers. Clinical guidelines are in place to assist care staff.</p> <p>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. There are guidelines and templates for reporting. The facility has collected data but evidence of data trending and analysis were not utilised. Also missing was</p>

		<p>consistent evidence of quality results being communicated to staff.</p> <p>An internal audit programme is established but is not fully implemented. Corrective action plans were not consistently sighted where opportunities for improvements were identified from internal audits.</p> <p>The health and safety representative interviewed confirmed their understanding of health and safety processes. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. New staff and contractors are orientated to health and safety. Health and safety is a regular agenda item in the monthly staff meetings.</p> <p>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>	FA	<p>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities. Individual incident/accident reports are completed for each adverse event with immediate action noted and any follow-up action required.</p> <p>A review of ten incident/accident forms (one choking, one pressure injury, eight falls) identified that forms were fully completed and included follow-up by a registered nurse. Neurological observations are carried out for any suspected injury to the head or unwitnessed fall. The clinical manager is involved in the adverse event process and signs off each event.</p> <p>The clinical manager was able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. They have reported section 31s for pressure injuries and two resident assaults. Public health was notified following an infectious outbreak in 2019.</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</p>	PA Moderate	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files reviewed (two registered nurses, three HCAs) included a recruitment process which included reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals.</p> <p>A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan; however, not all sessions have been held as scheduled and attendance rates are consistently low for most sessions. Both the low attendance rates and missed sessions have</p>

requirements of legislation.		<p>been identified and a corrective action plan developed. This previous area identified for improvement remains.</p> <p>There is an attendance register for each training session and an individual staff member record of training.</p> <p>Registered nurses are supported to maintain their professional competency. Two of nine registered nurses have completed their interRAI training. This low number of RNs trained in interRAI is a result of a recent high turnover of registered staff. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies.</p> <p>There are 17 HCAs that work in the dementia unit. Eleven have completed a national qualification in dementia training. Six who have commenced work in that area in the last 18 months have all commenced 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. Rosters implement the staffing rationale. There is a minimum of one RN on site at any time. Activities are provided five days a week in the rest home/hospital and six days a week in the dementia unit. Staff working on the days of the audit were visible and attending to call bells in a timely manner as confirmed by the residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers.</p> <p>The facility manager and clinical manager are rostered full time (Monday - Friday). Radius Windsor Court rosters the dementia unit separately to the remaining three wings.</p> <p>The dementia unit (Sunshine wing) had 18 residents at the time of audit. One RN provides four hours of care on the AM shift. The AM and PM shifts are rostered with two (long shift) HCAs on each shift. One HCA works from 10 pm to 7 am covering one hour of the PM shift and the night shift.</p> <p>The three remaining rest home/hospital wings (Main street wing, Sunset wing and Everlong wing) are rostered as one unit. There were 25 rest home residents and 22 hospital residents at the time of the audit. Two RNs are rostered on the AM shift, one on the PM shift and one on the night shift. Five long (eight hour) and two short shift HCAs work on the AM shift and three long shift HCAs and two short shift HCAs cover the PM shift (note one HCA crosses between the AM and PM shift). Two HCAs cover the night shift.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current</p>	FA	<p>Medication management policies and procedures comply with medication legislation and guidelines. Registered nurses and medication competent HCAs administer medications and have completed medication competencies and medication education. Medication administration was observed and complied with the administration policy. Medications are delivered in robotic rolls, and these are checked on delivery. There are three medication rooms within the facility. Monitoring of medication room temperatures was in place. All medications were within the expiry date, and a process has been implemented to ensure that all expired medications are returned to the</p>

legislative requirements and safe practice guidelines.		<p>pharmacy. The medication fridges are monitored, and temperatures were within the acceptable range. Eyedrops in use were dated on opening. There was one self-medicating rest home resident in the facility. A self-medicating assessment had been completed and the assessment was reviewed three monthly.</p> <p>Twelve medication charts (paper-based) were reviewed (four hospital, four rest home and four dementia care) and met prescribing requirements, the allergy status had been identified on all charts. 'As required' medications had prescribed indications for use.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a fully functional kitchen located within the service area of the building. Food and baking are prepared and cooked on site by a contracted service. The chef/kitchen manager is a qualified cook. She is supported by a second chef and kitchen assistants who have all completed food safety training. The four weekly seasonal rotating menu has been reviewed by a dietitian. There are menu options for special diets, food preferences and nutritional supplements are provided. The chef ensures residents of different cultures have their dietary needs met. There is special equipment available for residents if required.</p> <p>Meals are cooked and served directly to residents in the hospital dining room and plated and put into the scan box for the remaining residents. End-cooked temperatures and hot/cold box temperatures are monitored. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. The chef is notified of any changes to resident's dietary requirements. Nutritional supplements are provided by the kitchen.</p> <p>The temperatures of refrigerators, freezers and chiller are monitored and recorded. The chemical provider checks and monitors the performance of the dishwasher. All food is stored appropriately and dated. A cleaning schedule is maintained. The current food control plan expires on 31 March 2020.</p> <p>Residents in the dementia service have access to snacks 24 hours. Residents and the family members interviewed commented positively about the quality and variety of food served.</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>Registered nurses develop the long-term support plan from information gathered over the first three weeks of admission. Resident care plans reviewed were resident-focused and individualised. Assessed support needs including behaviour management plans (as appropriate) were included in the long-term care plans reviewed; with the exception of one file in the dementia care section that did not have a behavioural assessment or behaviour management plan in place.</p> <p>Short-term care plans are used for changes to health status and were sighted in resident files, for example for infections and wounds. Short-term care plans have either been resolved or if ongoing, transferred to the long-term care plan.</p>

		<p>Long-term care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Files reviewed provided evidence of relative's involvement in the care planning process where appropriate. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist and dietitian. Care plans were amended to reflect changes in health status and were reviewed on a regular basis.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>Registered nurses (RNs) and HCAs follow the detailed and regularly updated care plans and report progress against the care requirements each shift. If a resident's health status changes the RN initiates a GP or nurse specialist review. Relatives interviewed stated they are contacted for any changes in the resident's health.</p> <p>Wound assessment and care plans, wound review plans and evaluation notes were in place for residents with wounds. There were 26 wounds which included fifteen skin tears; one laceration; one scrape/abrasion; five skin conditions; one surgical wound; two venous ulcers and one haematoma. Wound documentation was complete, however wound care dressings for one resident whose file was reviewed did not reflect the correct frequency of dressing as stated in the wound care management plan.</p> <p>There was one resident with two hospital acquired stage three pressure injuries; this resident had wound nurse specialist involvement. Three residents had facility acquired stage two pressure injuries. One resident had a facility acquired stage one pressure injury. The wound nurse specialist, nurse practitioner and GP input were noted for wounds and PIs as acuity required.</p> <p>The service was aware of an increasing number of pressure injuries and the clinical manager stated that staff had received education focusing on pressure injury prevention. Registered nurses on interview stated that there were adequate pressure relieving resources available.</p> <p>RNs (interviewed) have access to specialist nursing wound care management advice as required. Staff have access to sufficient medical supplies, dressings and continence products. Resident files include continence assessments and plans as required.</p> <p>Electronic monitoring forms are completed and reviewed, for example, turning charts, food and fluid charts, blood pressure, weight charts and behaviour charts. Repositioning charts had not been completed as was required for one resident who required a repositioning chart.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as</p>	FA	<p>The service employs an activity coordinator and a diversional therapist. They alternate their time between hospital and rest home residents and residents in the dementia care unit. Both staff work Monday to Friday and alternate Saturdays. Healthcare assistants in the rest home, hospital and dementia unit incorporate activities for residents</p>

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>into their duty.</p> <p>The activity programme includes chair exercises, bowls, bingo, happy hour, newspapers, wall games, quizzes and cooking. One-on-one time is spent with residents who choose not to or are unable to participate in group activities. There are regular van outings so residents can access church groups, concerts, cafés and the Working Men's Clubs and socialise with residents from other rest homes. Visitors from the community include entertainers, a line dancing group, kindergarten, day care, school, pet therapy, and a local lady visits to reminisce with the residents. The activity programme for dementia care residents is flexible and focused on meaningful activities, small group activities and one-on-one time.</p> <p>All resident files reviewed have an individual recreational assessment and activity plan that is evaluated at least six monthly. Residents and families interviewed commented positively on the activity programme. Residents have the opportunity to feedback on the activity programme through resident meetings, surveys, family emails and one to one feedback.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Six monthly evaluations of the plan of care had been evaluated. Written evaluations identify if the resident/relative goals are met or unmet. Short-term care plans sighted on eCase have been evaluated and resolved or added to the applicable long-term care plan if the problem is ongoing. There is at least a three-monthly review by the GP.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness which expires 17 June 2020. There is a maintenance person on site 40 hours per week. Contractors are used as required.</p> <p>Electrical equipment was tested and tagged on 15 February 2019. Medical equipment including hoists and scales are checked/calibrated annually (September 2019). Hot water temperatures are monitored monthly. Testing is random in resident areas and were within the acceptable range.</p> <p>The communal lounges and hallways are carpeted. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents' rooms in the rest home and hospital area are carpeted, but in the dementia unit there is vinyl. All showers and toilets have non-slip vinyl flooring. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The external areas and gardens were well maintained. The dementia unit has a large fenced off garden. All outdoor areas have seating and shade. There is safe access to all communal areas.</p>

		HCA's and RNs interviewed stated they have adequate equipment to safely deliver care for all residents.
<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>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme (link 1.2.3.6). The infection control coordinator/clinical manager holds a recognised infection control qualification. All infections are reported in the eCase system and a monthly report including end of month trends and analysis is able to be generated using eCase (link 1.2.3.6). Data including corrective actions are discussed at the management and facility meetings (link 1.2.3.8). The service submits data monthly to Radius head office.</p> <p>There has been one Norovirus outbreak in March 2019. The DHB and public health authorities were notified. The action plan was sighted, the facility was placed in lockdown; families were notified; signage was in place; personal protective equipment (PPE) stations were set up. Handrails and hard surfaces were wiped down, housekeeping and laundry precautions were in place. The public officer of health from the DHB visited the site. Those affected with norovirus included 18 residents and five staff. Processes were reviewed following the outbreak to determine service improvement opportunities. All PPE boxes were updated following the outbreak.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The clinical manager is the restraint coordinator. At the time of the audit one hospital level resident was using bedrails as a restraint and two hospital level residents had voluntarily requested bedrails as enablers. One file of a resident using an enabler was reviewed. An enabler assessment was completed. There was documented evidence of the resident giving consent for the use of the enabler and this enabler was linked to their care plan.</p> <p>Staff are scheduled to attend annual restraint minimisation training (link 1.2.7.5).</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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	<p>A 2019 annual resident/relative survey was completed in June 2019 (sample = 13) with the majority of respondents either satisfied or very satisfied. A food satisfaction survey was completed in August 2019 (sample 22) and twenty respondents were either satisfied or very satisfied. There was no evidence in staff meeting minutes that they were informed regarding these results.</p> <p>The internal audit programme was not fully implemented in 2019. Data collected (eg, falls, skin tears, bruises) is collected electronically using eCase but there was no evidence provided by the facility manager or clinical manager to evidence that this data is trended and analysed. Nor was there evidence to reflect that staff are informed of the internal audit results including instances where corrective actions are required.</p>	<p>i) Twelve of thirty-six audits were not completed in 2019.</p> <p>ii) Seven of eleven audit scores were below 95% without evidence of a re-audit in eight weeks as per Radius policy.</p> <p>iii) Quality data that is being collected in not being trended and evaluated.</p> <p>iv) Quality results, in particular internal audit results, complaints received and corrective</p>	<p>i) Ensure internal audits are completed as per the audit schedule.</p> <p>ii) Ensure that internal audits with scores below 95% are repeated within eight weeks as per Radius policy.</p> <p>iii) Ensure that quality data that is being collected (eg, falls,</p>

			action plans, are not routinely communicated to staff.	bruising, skin tears, medication errors) is trended and evaluated. iv) Ensure that quality results are regularly communicated to staff. 90 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	Corrective action plans are not consistently developed where opportunities for improvements are identified.	Corrective action plans were not consistently being developed where areas for improvements were identified (eg, internal audits with scores below 95%).	<p>Ensure corrective action plans are consistently developed where opportunities for improvements are identified.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	An education planner for the year is developed by head office and includes all mandatory sessions plus others relevant to the service. Not all training sessions have been held and attendance numbers continue to be low. The clinical manager is responsible for implementing the programme and facilitating staff attendance.	<p>i) Not all planned education sessions have taken place as scheduled. Work is underway to complete mandatory training in four-hour blocks (implemented November 2019).</p> <p>ii) Attendance numbers at scheduled mandatory education sessions (including those who have</p>	<p>i) Ensure all scheduled training is delivered as planned.</p> <p>ii) Ensure all staff complete their mandatory training.</p> <p>60 days</p>

			completed competency questionnaires) have been less than 50% for most sessions.	
<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	<p>Six files were reviewed. Initial assessments and an interim care plan had been developed by registered nurses within 24 hours of admission for all residents including the respite care resident. Initial interRAI assessments for two of the long-term resident files reviewed had not been completed within 21 days of admission. Six monthly interRAI assessments for 16 long-term residents were also overdue. Electronic evaluations (multidisciplinary – MDT case conference) are completed at least six monthly.</p>	<p>Two resident files (one dementia care and one hospital care) reviewed did not have interRAI assessments completed within 21 days of admission. Six monthly interRAI assessments for 16 long-term residents were also overdue.</p>	<p>Ensure all initial interRAI assessments are completed within the required timeframe.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	<p>Six files were reviewed, two hospital care, two rest home care and two dementia care residents. Registered nurses had developed long term support plans from information gathered during admission. One of the dementia care residents did not have a behavioural assessment undertaken at admission and did not have a behaviour management care plan in place. The resident's behaviours had been triggered in the interRAI assessment and this resident had recently assaulted a staff member and another resident. During the audit the residents file was updated with a behaviour management plan, which reflected the behaviours of concern.</p>	<p>One residents file was reviewed and there was no behaviour assessment in place, or behaviour management plan. The interRAI assessment had triggered behaviour as a concern and the resident had recently assaulted a staff member and another resident.</p>	<p>Ensure behaviour assessments and behaviour management care plans are in place for all residents where behavioural concerns are identified as being a care need.</p> <p>30 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>RNs (interviewed) have access to specialist nursing wound care management advice as required. Staff have access to sufficient medical supplies, dressings and continence products. Resident files include continence assessments and plans as required.</p> <p>Electronic monitoring forms are completed and reviewed, for example, turning charts, food and fluid charts, blood pressure, weight charts and behaviour charts. Neurological observations had been completed as per protocol.</p> <p>i) Wound care management was not undertaken at the frequency stated in the wound care management plan for one file reviewed. The file was updated on the day of the audit to reflect the current wound care management requirements.</p> <p>ii) Repositioning charts were complete and sighted for residents whose files were sighted with the exception of one resident who required repositioning due to a stage three pressure injury to the sacrum. This resident did not have a repositioning chart in place, although the care plan had stated that a repositioning chart was required. The repositioning chart was implemented on the day of the audit.</p>	<p>i) Wound care management had not been undertaken at the required frequency for one wound care management plan reviewed.</p> <p>ii) A repositioning chart was not in place for one resident whose file stated that a repositioning chart and regular repositioning was required, this resident had a stage three sacral pressure injury.</p>	<p>i) Ensure wound care management occurs at the correct frequency as stated in the wound care management plan.</p> <p>ii) Ensure all residents requiring repositioning charts have repositioning charts in place and the resident is repositioned and the chart is documented at the required frequency.</p> <p>60 days</p>
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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.