

Radius Residential Care Limited - Althorp

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: Althorp

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

Dates of audit: Start date: 30 July 2020 End date: 31 July 2020

Proposed changes to current services (if any): This audit included verifying the reconfiguration of psychogeriatric and dementia beds. The number of psychogeriatric beds has been reduced from three 15 bed units to two 15 bed units (30 beds). The number of dementia unit beds have increased from one 15 bed unit to two 15 bed units (30 beds).

Total beds occupied across all premises included in the audit on the first day of the audit: 93

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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 93 residents.

The service is managed by a newly appointed facility manager (non-clinical) who has previous experience in managing aged care facilities. She is supported by a Radius regional manager and clinical nurse manager who is an experienced registered nurse. Residents, relatives and the GP interviewed spoke positively about the recent changes at Althorp.

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 the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and the general practitioner.

This audit also included verifying the reduction in psychogeriatric beds and increase in dementia level beds.

Nine of nine findings from the previous certification audit relating to communication, complaints, adverse events, staffing, assessment and care plan timeframes, care plans, interventions, evaluations and medication reconciliation have been addressed.

Fourteen of fourteen findings from the HealthCERT inspection relating to activation and documentation of EPOA, facility and clinical management, documented quality improvements, adverse event reporting, dementia units training, staffing, assessments, care

plans, evaluations, re-assessments, activities, nutritional requirements, environment and environmental restraint have been addressed.

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.		Standards applicable to this service fully attained.
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An experienced (non-clinical) facility manager was employed in March 2020 to oversee operations. She is supported by the regional manager, a clinical nurse manager/registered nurse (RN) and two clinical team leaders/RNs.

The quality and risk management programme being implemented includes a service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Meetings are held monthly with staff to discuss quality and risk management processes. Staff are kept informed of quality improvements and outcomes via meetings and meeting minutes.

Resident and family meetings are held bi-monthly. Their input is regularly sought including via satisfaction surveys. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported with evidence of the RN on duty and clinical nurse manager following up on adverse events. Improvements are generated where identified.

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 including impromptu toolbox talks.

Residents receive appropriate services from suitably qualified staff. 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.		Standards applicable to this service fully attained.
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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 professionals and a team approach is evident in the overall resident electronic 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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A current building warrant of fitness is posted in a visible location. Reactive and preventative maintenance programmes are being implemented with oversight by the property services manager. Residents have independent access to outdoor areas during daytime hours. Call bells are placed next to residents and were in working order during the audit. They are regularly checked by maintenance staff.

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 behaviours. 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 is the clinical team leader for the dementia and psychogeriatric units. She 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.

The infection control coordinator (registered nurse) working together with the clinical team leader, is responsible for the collation of infection control data and communicating outcomes, trends and analysis to the clinical/quality teams. 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. There has been one suspected norovirus outbreak. There are rigorous COVID-19 screening procedures for all staff, visitors and contractors.

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	22	0	0	0	0	0
Criteria	0	50	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	<p>Seven resident files were reviewed, (one rest home, two hospital level including one resident in a palliative care bed, two dementia level of care and two psychogeriatric level of care). Informed consent processes are discussed with residents (as appropriate) and families on admission. Written general consents and specific consents (eg, influenza vaccine consents) were sighted on the electronic files. Advance care plans where known were available on the resident files.</p> <p>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 eCase alerts for each resident identifies the EPOA and the activation status. The previous shortfall from the HealthCERT inspection has been addressed. The four registered nurses and six 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>
Standard 1.1.13: Complaints Management	FA	<p>The service has a complaints policy that describes the management of the complaints process. A complaints procedure is provided to residents at entry. Feedback forms are available for residents/relatives in various places around the facility.</p>

<p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>There is a complaint register that includes relevant information regarding each complaint lodged. The number of complaints received each month is reported monthly to staff via the quality/health and safety meeting minutes. These meeting minutes are retained in the staffroom for staff to read. There have been five complaints lodged in 2020 (year-to-date) as per the register and all five complaints have been documented as resolved with evidence of each complaint being acknowledged and investigated within timeframes as determined by the Health and Disability Commissioner (HDC). Interviews with families confirmed that they are satisfied with the service and have not had any complaints. These are improvements from the previous certification audit.</p> <p>One complaint/coroner's inquest lodged with HDC (received prior to the last certification audit) remains open. Numerous quality improvements related to this complaint have been implemented addressing staffing levels, staff training, the timeliness of registered nursing (RN) re-assessments and development of clearer lines of communication with families.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Four residents (three hospital, one rest home) and four family members (three psychogeriatric and one rest home/dementia) stated they were welcomed on entry and were given time and explanation about services and procedures. The family members interviewed confirmed that they are informed of changes in the health status of residents or if an adverse event occurs. This was documented in all 12 electronic incident forms sampled. This is an improvement from the previous certification audit (July 2019) and HealthCERT inspection (October 2019).</p> <p>Resident/relative meetings are held bi-monthly. The facility manager has an open-door policy. The manager encourages open communication with staff, residents and family and understands that effective communication is the pathway to change and success.</p> <p>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>	<p>FA</p>	<p>Radius Althorp is part of the Radius Residential Care Group. The service provides rest home, hospital, dementia level and psychogeriatric level care for up to 117 residents. Five beds (in hospital wing) are funded by the DHB for GP (one bed) and palliative care (four beds). There are 10 dual-purpose level care beds in the rest home/hospital wings.</p> <p>On the day of the audit there were 93 residents. There were seven rest home; thirty-nine hospital residents (including one palliative care, two ACC, and one younger person with a disability (YPD); seventeen residents in across dementia units and thirty residents across the two 15-bed psychogeriatric (PG) units. Residents in the dementia/rest home and hospital are under the age-related residential care (ARRC) contract with the exception of the ACC, YPD and palliative care resident (who was in a DHB funded bed). Residents in the PG units are under the</p>

		<p>ARHSS contract (aged specialist hospital).</p> <p>This audit included verifying one wing previously used psychogeriatric (PG), as suitable for dementia level residents. This has resulted in a total decrease in PG beds from 45 PG beds to 30 PG beds and an increase in dementia beds from 15 beds (1 unit) to 30 beds (across 2 units).</p> <p>The Radius Althorp strategic plan 2020-21 is linked to the Radius Residential Care Group strategies and business plan targets. Radius Althorp has worked through a significant change process to ensure that staff and resources are placed to provide individualised, safe and secure care for residents. This process has involved a high level of senior support including support from the DHB, external consultants and Radius senior staff.</p> <p>The mission statement is included in information given to new residents/families and staff. 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 since March 2020. She has held managerial roles in aged care since 2008 with experience in managing large residential aged care facilities including dementia care services. Previous to her work in aged care, she worked in the hospitality industry. She is supported by the regional manager (RN), a clinical nurse manager who has been in the role for seven months and qualified as an RN in 2013, an eCase (electronic system) coordinator and two clinical team leaders/RNs.</p> <p>The facility manager and clinical nurse manager 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 nurse manager is in charge with support from the regional manager and clinical team leaders.</p> <p>Consequent to the HealthCERT inspection, a Radius regional manager took responsibility to move the service forward and to orientate the current facility manager through the end of March 2020. This was in addition to the current regional manager for the facility who continues to visit Radius Althorp as per Radius requirements and provides ongoing support and leadership. The management team were assisted by a DHB appointed clinical advisor while addressing areas identified for improvements.</p> <p>The clinical manager has been in her role since Jan 2020. She qualified as an RN in 2013 and has worked in the aged care industry for four years.</p> <p>The clinical lead for PG and dementia has worked in the role at Althorp since 2018. Initially she worked in the PG and dementia units as a staff RN to gain experience. At the time of the audit, plans were being implemented to promote the clinical lead working in PG and dementia to clinical manager.</p> <p>This previous area identified for improvement in HealthCERT inspection is now being met.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisational business plan includes quality goals and risk management plans. The quality plan (April 2020-21) includes site-specific goals and proposed actions, specifically addressing required improvements identified on the previous HealthCERT inspection report. Quality and risk performance are reported across facility meetings and to the regional manager. There are monthly quality/health and safety meetings where quality data and indicators are discussed. Minutes of these meetings are made available to all staff in the staffroom and are also highlighted in the monthly staff meetings. Required actions and resolutions are documented. Resident/relative meetings are bi-monthly. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. Interviews with managers (regional manager, facility manager, clinical nurse manager, property services manager) and staff (one clinical team leader/RN, four RNs, one eCase coordinator, three activity coordinators, one diversional therapist, one kitchen manager, six healthcare assistants [HCAs - one AM shift and five PM shift working across all wings]) reflected a team of individuals who are collectively involved and provide input into the facility's quality and risk management programmes.</p> <p>The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The 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.</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. Data is collected in relation to a variety of quality activities and an internal audit schedule is being implemented. Results are communicated in monthly quality/health and safety meetings and staff meetings. Daily operational meetings are held to discuss clinical, housekeeping, laundry, maintenance, staffing, specific resident reviews, and issues arising. Meetings are robust and consistently held.</p> <p>Areas of non-compliance identified through quality activities are actioned for improvement. Quality initiatives over the past six months are extensive with attention focussed around maintaining adequate and safe staffing levels, enhancing the staff learning experience and reinforcing lines of communication. Protected mealtimes are implemented allowing RNs to assist with feeding residents, meaningful activities have been implemented and family meetings reintroduced. A falls committee is in place to provide leadership in reducing the number of residents' falls. Falls are actively monitored. Charting of falls location, monitoring of times of falls and individual fall reviews are documented. Falls prevention strategies include intentional rounding, sensor mats, post-falls reviews and individual interventions.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. One health and safety representative (property services manager) interviewed confirmed their understanding of health and safety processes. A robust orientation programme for new staff and external contractors is being implemented. Risk</p>
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		<p>management, hazard control and emergency policies and procedures are in place. Hazard identification forms and an up-to-date hazard register are in place.</p> <p>Previous shortfalls identified in the HealthCERT inspection report have been addressed and implemented.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise, and debriefing. There is a discussion of incidents/accidents at the monthly staff and quality/health and safety meetings. A review of 12 incident/accident electronic forms (one absconding, two witnessed falls, three unwitnessed falls with neuro observations, three pressure injuries, three medication errors) identified a review by a RN at the time of the incident. The clinical nurse manager signed off each adverse event to indicate any actions/outcomes implemented. Family interviews confirmed that they are kept informed. Previous findings from the last certification audit and the HealthCERT inspection report have been addressed.</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 were for pressure injuries, resident aggression, and one suspected norovirus outbreak (negative outcome).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Seven staff files reviewed (one clinical nurse manager/RN, one clinical team leader/RN, five HCAs) included 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 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 twenty-one RNs have completed their interRAI training. Registered nurses are supported to maintain their professional competency. A minimum of one staff is available 24/7 with a current first aid/CPR certificate.</p> <p>There are 34 HCAs who work across the two dementia units and two PG units. Thirty have completed the required dementia standards and four HCAs are in progress of completing. All four HCAs have been employed for less than 18 months. The clinical nurse manager reported that there is less movement of staff between the hospital/rest home wings and the dementia/PG wings creating more of a bubble of staff working with the dementia/PG level</p>

		<p>residents only. A significant amount of time and effort has gone into staff dementia training, in particular, managing challenging behaviours. This is a significant improvement from the previous certification audit and HealthCERT inspection.</p> <p>The clinical manager stated that approximately 95% of agency (RN and HCAs) have worked at the facility many times. For first time agency staff; they are orientated to the facility during their first visit (eg, where things are and how their electronic database works (e-case). In addition, there is an e-case manual for guidance. All agency staff have their own e-case log-in. The agency is responsible for ensuring RNs are medication competent.</p> <p>The service has responded to recent complaints, survey results and corrective actions plans by implementing a number of toolbox talks as well as sessions provided by the DHB mental health services for the older person. Training has been focused on person-centred care and communication. The frequency of toolbox talks was escalated during the COVID-19 lockdown to help keep staff informed.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The clinical nurse manager and clinical team leaders are registered nurses (RNs) who are employed Monday - Friday 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 are rostered on duty 24 hours a day, seven days a week.</p> <p>The service is divided into six separate units (two psychogeriatric units, two secure dementia units and two hospital/rest home units). Staff turnover has reduced significantly and staffing levels have increased since the last certification audit and HealthCERT inspection.</p> <p>Ongoing recruitment is in place with a significant drop in the use of agency staff. Only five agency staff were called in during the last roster as compared to as many as 48 during the COVID-19 lockdown. Four RNs and two healthcare assistants have recently been appointed and were scheduled to begin work next month. Interviews with family confirmed that staffing levels are adequate to meet the needs of the residents.</p> <p>Best unit (15 of 15 PG residents): one RN covers each shift for 24/7 RN care with the night shift RN working across the two PG units (Best and Scott). Three HCAs staff cover the AM shift, three HCAs cover the PM shift and two HCAs cover the night shift.</p> <p>Scott unit (15 of 15 PG residents): one RN covers the AM and PM shifts. Three HCAs staff cover the AM shift, three HCAs cover the PM shift and two HCAs cover the night shift with support from the RN.</p> <p>Church unit (15 of 15 dementia residents): one RN (clinical team leader) covers Monday – Friday and a second RN covers four-five days a week for seven day a week cover. Two HCAs cover the AM shift, two HCAs cover the PM shift (one long and one till 10 pm), and one HCA covers the night shift.</p> <p>Munroe unit (2 of 15 dementia residents). This unit opened one week prior to the surveillance audit. It was staffed</p>

		<p>with one HCA on each shift.</p> <p>McLeod unit (19 hospital, 5 rest home): The clinical manager and one clinical team leader work in the hospital Monday – Friday on the AM shift. She is supported by one RN who covers morning and afternoon shift. Four HCAs cover the AM and the PM shifts (two long and two short) and two HCAs cover the night shift with support from the RN in Reuben unit.</p> <p>Reuben unit (20 hospital, 2 rest home): One RN covers morning, afternoon and night shift. Four HCA (three long and one short) cover the AM shift, four HCA (two long and two short) cover the PM shift and one HCA cover the night shift with support from the other HCA in McLeod.</p> <p>This previous area identified for improvement during the last certification audit and HealthCERT inspection is now being met.</p> <p>The roster is able to be changed in response to resident acuity.</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>	FA	<p>There are policies and procedures in place for all aspects of medication management. There are two medication rooms in the hospital building, one in each wing and both have secure keypad access. There are medication rooms in each unit (two dementia and two psychogeriatric) in the main building. Registered nurses or senior HCAs administering/checking medications have completed their annual competency assessment and attended medication education. Registered nurses have completed syringe driver training. Medication fridges and medication room temperatures had daily temperature checks recorded and were within normal ranges. The facility uses a robotics pack medication management system for the packaging of all tablets. Medication reconciliation of medications on delivery is documented. The previous finding from the certification audit around medication reconciliation has been addressed. There is an impress stock in the hospital unit that is checked regularly for stock levels and expiry dates. Eyedrops and other liquid medications were dated on opening. There were no residents self-administering on the day of audit.</p> <p>The facility utilises a paper-based medication management system. Fourteen medication charts were reviewed (four psychogeriatric, four dementia, two rest home and four hospital). All charts reviewed had photo identification and allergy status documented. All medication charts evidenced three monthly reviews by the GP. Prescribed medication is signed after being administered. All 'as required' medication prescribed had indications for use documented by the GP. Effectiveness of 'as required' medication administered was documented in the progress notes. There are no standing orders. The RNs and GP use a telephone order system which is managed according to protocol.</p>
<p>Standard 1.3.13: Nutrition, Safe Food,</p>	FA	<p>All meals are prepared on-site by a contracted food service. The kitchen manager/chef is supported by two cooks (8 am-5 pm) and two morning kitchenhands and two afternoon kitchenhands on duty daily. The four weekly winter</p>

<p>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>		<p>and summer menu has been reviewed by a dietitian at the head office for the contracted service. The menu includes pureed and vegetarian options. Special dietary requirements are provided including normal, pureed/soft, gluten free and dairy free foods. The menu can be changed to meet 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 and any weight loss. Nutritional needs and specific needs around mealtime were included in the care plans. The previous finding from the HealthCERT inspection has been addressed. Pureed meals are provided and presented in moulded shapes (sighted). Resident dislikes and allergies 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, cheese and crackers and home-baking readily available for the dementia care and psychogeriatric residents.</p> <p>The food control plan expires 30 March 2021. Daily food control plan requirements are entered into a computer-based system accessible from head office. The temperatures of refrigerators, freezers, chiller, dishwasher, incoming chilled goods, end-cooked foods and serving temperatures on all foods are taken and recorded on the food service app. Fridge temperatures are taken daily in the unit kitchenettes. All food is stored appropriately, and date labelled. Cleaning schedules are maintained. All kitchen staff have completed orientation and ongoing food safety training.</p> <p>The kitchen manager receives feedback from resident/relative meetings and visits to residents. The food survey in April 2020 demonstrated 88% satisfaction with meals. Residents and the family members interviewed were very happy with the quality and variety of food served.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All appropriate personal needs information is gathered during admission in consultation with the resident (as appropriate) and their relative/EPOA. Information from medical notes, discharge summaries and allied health professional visits and letters are used to form the basis of the electronic initial assessment and long-term care plan. InterRAI assessments were completed in all long-term resident files reviewed. An initial nursing assessment and an interim care plan was completed for all residents including the resident under palliative care. Personal needs, outcomes and goals of residents are identified with appropriate interventions and personal strategies documented. 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, nutritional, Abbey pain assessments, behaviour assessments, mobility and continence. Behaviour assessments had been completed for the dementia care and psychogeriatric files reviewed, with detailed and personalised interventions for de-escalation of behaviours. Activities assessment is completed involving the family/EPOA.</p> <p>Family interviews stated they were involved in the assessment process on admission and ongoing.</p>

		The previous shortfall from the HealthCERT inspection has been addressed.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Six long-term resident care plans were reviewed on the electronic resident management system. The palliative care resident was not required to have a long-term care plan. The palliative care resident had an interim care plan in place that documented support and interventions for current problems identified on assessment such as a nutritional plan for dysphagia and low body weight and a pain management plan. Long-term care plans reviewed recorded the resident's problem/need and objectives/interventions and personal strategies to support the resident needs and goals. All resident care plans are developed in consultation with family/EPOA and resident (where appropriate).</p> <p>A care plan summary for each resident provides a guide for HCAs to follow. Care plans have been developed for specific conditions and problems including falls risk, behaviour management, pain management, continence and bowel management, and nutritional management. There were additional plans for the management of diabetes. A risk plan was in place for residents with identified risk including the risk of absconding, triggers and interventions including activities. Staff interviewed reported they found the plans easy to follow. The involvement of allied health professionals including physiotherapist, dietitian and the mental health services for the older person and psychogeriatrician were linked to the care plans. Short-term care plans are utilised for short-term problems and are regularly reviewed, resolved or if an ongoing problem added to the long-term care plan.</p> <p>The previous finding around care plans from the certification and HealthCERT inspection has been addressed.</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>	FA	<p>Clinical team leaders, registered nurses (RNs), and healthcare assistants follow the care plan and report progress against the care plan each shift. If a resident's condition changes the RN initiates a GP, NP or allied health professional visit. If external medical advice is required, this will be actioned by the GP. The mental health services for the older person team have been involved in assisting the RNs with behaviour assessments and appropriate placement of residents within the two psychogeriatric units. One unit is identified as a quieter unit than the other. The interventions and reviews for behaviours are clearly documented within care plans. The GP is informed of any significant changes to health including weight loss. The previous shortfalls around reporting and documenting recommendations within care plans from the certification and HealthCERT audit has been addressed.</p> <p>Staff have access to sufficient medical supplies (eg, dressings). Wound assessment, wound management and evaluation forms were in place for 19 wounds (12 hospital residents, three rest home, two dementia care residents and two psychogeriatric residents). There was a total of 11 pressure injuries with one resident with three pressure injuries and one resident with two pressure injuries. There were 10 hospital residents and one psychogeriatric resident with pressure injuries. There was one stage one, two stage two, three stage three, one stage four, one unstageable and one deep tissue. Section 31s were completed for stage three, unstageable and deep tissue injuries. There were nine community-acquired pressure injuries and two facility-acquired (one stage two and one deep tissue injury). Photos and short-term care plans were in use. There is access to a wound nurse specialist.</p>

		<p>Advised that the facility acquired pressure injuries have improved however the community acquired PI's have been chronic.</p> <p>There have been frequent toolbox talks at handovers including prevention and management of pressure injuries Formal education has been delayed due to COVID-19.</p> <p>The RNs interviewed confirmed there is adequate pressure relieving equipment available and in use including alternating air mattresses, pressure relieving cushions and bootees.</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>Interviews with registered nurses and HCAs demonstrated understanding of the individualised needs of residents. Monitoring forms reviewed included two hourly turning charts, monthly weight and vital sign monitoring, pain monitoring food and fluid charts, behaviour charts, blood sugar monitoring and daily activity checklists. Neurological observations had been completed for unwitnessed falls. The previous certification shortfall around neurological observations has been addressed.</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>	FA	<p>A qualified diversional therapist (DT) leads the activities team, which includes three activities coordinators (one has commenced the DT course). All members of the activity's team works 30 hours per week from 9.30 am-4 pm Monday to Friday. Two activities coordinators cover the hospital section, one in McLeod wing and the other in Reuben wing. The DT and one activity coordinator implement activities in two units each (one dementia and one psychogeriatric). The DT has commenced attending regional activity meetings. The previous finding from the HealthCERT inspection regarding mentorship has been addressed.</p> <p>Each unit has separate activity programmes which includes group activities and one-on-one time. Activities are set for weekends such as church services, walking groups, movies as well as other staff directed activities. Each unit programme has a guide of indoor activities, outdoor activities and quiet time activities. Dementia and psychogeriatric residents have individual memory boxes in their rooms with contents of interest to the individual resident. Each unit has an activity trolley set up with a range of activities accessible to residents, family and staff. There is a manual with each trolley outlining the use of activities items. Staff leave messages for the activity team when they have utilised activities for residents. On the day of audit, residents in all areas were observed being actively involved with a variety of activities either in a group with the activity coordinator or one-on-one time with HCAs. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan.</p> <p>The activities programme 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, exercise, board games, walking groups, bowling challenge, pampering sessions, floor games, newspaper reading, table activities,</p>

		<p>gardening, flower arranging, high tea, movies, music, reminiscing, sing-a-longs, colouring art and happy hours. The programme for dementia and psychogeriatric residents also includes individual time and household activities. There is a men's cave (group), ladies knit and knatter group and legend group. The previous finding from the HealthCERT inspection regarding meaningful activities has been addressed.</p> <p>There are supervised combined unit activities and entertainment in the large recreational room that has a kitchenette and doors opening out to a safe outdoor area. Entertainers and church groups visit regularly. Community links include the mobile library visit and visiting college students. Themes and festive occasions are celebrated. There are weekly outings and scenic drives for all residents. The activity team have current first aid certificates. During the COVID-19 lockdown each unit stayed within their bubble with unit activities with photos and face time with families.</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 as part of the MDT case conference with the RN and resident/relative.</p> <p>Family members are invited to the two monthly unit meetings where residents (as appropriate) and family members can provide feedback on the programme. 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>	FA	<p>The registered nurses evaluate the interim care plans within three weeks of admission. The long-term care plans of five long-term residents had been evaluated six monthly. One rest home resident had not been at the service six months. Case conference checklists are signed by those present including the family/EPOA and GP. The care plan evaluations that have been completed, document if the resident goals have been met or unmet. If family/EPOA have been unable to attend the RN contacts them for input and discussion around the resident's care. The discussion is recorded under correspondence in the resident electronic file. The previous finding from the certification audit and HealthCERT inspection has been addressed.</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.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	FA	<p>Referral to other health and disability services is evident in the group of resident files reviewed. 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 nurse manager for nursing specialists. Specialist medical referrals are made through the GP. The clinical nurse manager and registered nurses interviewed provided examples of where a resident's condition had changed, and the resident was reassessed. There was evidence of</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.		where a resident's condition had changed, and the resident was reassessed for a higher or different level of care from psychogeriatric level of care to hospital level and from rest home level to dementia level of care. The previous finding from the HealthCERT inspection report has been addressed. Discussion with the RNs identified that the service has access to a wide range of support either through the GP, DHB specialists, mental health services for the older person, assessment teams and contracted allied health services.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>The building holds a current building warrant of fitness that expires on 22 November 2020. The facility is in two buildings, a hospital/rest home building, which has three wings (McLeod East, McLeod West, and Reuben (upstairs)); and a dementia facility/psychogeriatric (PG) section comprising of four 15-bed wings. One PG wing was recently decommissioned and has recently reopened as a dementia wing. The movement of PG residents from this unit was coordinated in collaboration with the DHB mental health services team. The unit was remodelled and is now suitable for 15 dementia residents. Renovations included replacing carpet, lino and dining chairs. The glass display at the entrance to the unit was redesigned to not impair visual observations of residents. New paint and pictures have given the unit a fresh and inviting look and dementia residents are currently being admitted with two residents in the unit and a third admission taking place during the audit. These are improvements from the previous HealthCERT inspection.</p> <p>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 have non-slip vinyl flooring. The facility has sufficient space for residents to mobilise using mobility aids and residents were observed moving around freely. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>The external areas are well maintained. Residents have independent access to safely designed external areas during the daytime. This is an improvement from the previous HealthCERT inspection. There is adequate seating and shade.</p> <p>Medical and electrical equipment servicing takes place annually by an approved contractor. Residents were observed to have access to their call bells and the call bells were in good working order. They are regularly tested by property services.</p>
Standard 3.5: Surveillance	FA	Infection surveillance is an integral part of the infection control programme and is described in the Radius Althorp infection control manual. Individual resident infection reports are completed for all infections which includes signs

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		<p>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 coordinator is new to the role and is supported by the previous infection control coordinator, clinical nurse manager and the Waikato regional manager who has a master's in infection control. The infection control coordinator provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Areas for improvement are identified, with corrective actions developed and followed up. This data is monitored and evaluated monthly and quarterly benchmarking against other Radius facilities occurs. During the COVID-19 lockdown a COVID-19 committee was formed who met daily and provided toolbox talks with staff and regular updates to residents and family. There were resources available and support from the DHB. There is plentiful personal protective equipment available on-site. Hand sanitisers are readily available throughout both buildings. There are robust screening procedures at the entrance of both buildings including a written health declaration and temperature checks for all staff, visitors and contractors.</p> <p>A suspected norovirus outbreak in April 2020 in one psychogeriatric unit was reported to the DHB. The outbreak was well contained with six residents affected. All faecal samples were negative.</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. 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 have been unsuccessful to keep the resident safe. There were no restraints being used at the time of this audit and two hospital level residents were using enablers (bedrails).</p> <p>One resident file for enabler use was selected for review. There was documented evidence of an enabler assessment and resident consent for use of the enabler. The use of the enabler was linked to the resident's care plan. Enablers are reviewed three-monthly to ensure the resident using the enabler remains able to request the enabler (bedrails) to be on/off.</p> <p>Staff receive training and education around restraint, enablers and challenging behaviours at orientation and ongoing as part of the organisation's training plan.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval</p>	FA	<p>The restraint coordinator is the clinical team leader for the dementia and psychogeriatric units. She has held this role for three years.</p> <p>Staff are able to bypass the security lock code to outdoor areas in order to allow residents to have free access to the outdoors during daytime hours. All doors in the dementia wings to enclosed outdoor areas (dementia and PG units) are easily opened and staff reported that staffing levels allow them to safely monitor residents who venture outdoors. These are improvements made following the previous HealthCERT inspection.</p>

of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		There were no restraints being used at the time of this audit.
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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.

No data to display

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.