

Radius Residential Care Limited - Radius Millstream

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Radius Residential Care Limited

Premises audited: Radius Millstream

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: 26 November 2020 End date: 27 November 2020

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 86

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

General overview of the audit

Radius Millstream is owned and operated by Radius Residential Care Limited. The service provides cares for up to 99 residents requiring rest home, hospital (medical and geriatric) or dementia level care. On the day of the audit, there were 86 residents. The service is managed by a facility manager who has been in the role since 2016 with support from the Radius regional manager, and a clinical nurse manager. Residents, relatives, and the GP interviewed spoke positively about the service provided.

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

This audit identified areas for improvement around neurological observations and care plan interventions.

The service has exceeded the standard around communication and reducing unintentional weight loss in the dementia unit.

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.

All standards applicable to this service fully attained with some standards exceeded.

The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights.

The personal privacy and values of residents are respected. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review process. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Care plans accommodate the choices of residents and/or their family. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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A facility manager and clinical nurse manager are responsible for the day-to-day operations. The quality and risk management programme includes service philosophy, goals, and a quality planner. Quality activities, including Radius key performance indicators, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings are held monthly, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff that is specific to their role and responsibilities. Ongoing education and training programmes are in place, which include in-service education and competency assessments.

There is a roster that provides sufficient and appropriate coverage for the effective delivery of care. Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files included medical notes by the contracted general practitioners and visiting allied health professionals.

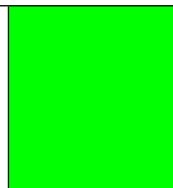
The activity team implement the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent senior healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

All meals are cooked on site. The kitchen service is provided by an external catering company who employ the kitchen staff at Radius Millstream. The menu has been approved by a dietitian, there is a current food control plan in place. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were satisfied with the food service. Snacks are available at all times.

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 has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and most have their own ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounges and dining areas throughout the facility in addition to its main communal areas. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible, and the dementia garden is secure. Cleaning and laundry staff are providing appropriate services.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

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.

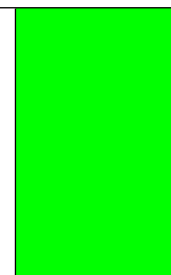


Standards applicable to this service fully attained.

The facility is restraint-free. Staff receive regular education and training on restraint minimisation and managing challenging behaviours. There were no enablers in use at the time of the audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidenced that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. The facility has responded promptly and appropriately to the Covid pandemic, and Ministry of Health and Public Health directives.

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	2	41	0	2	0	0	0
Criteria	2	89	0	2	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme.</p> <p>Discussions with staff including, including eight health care assistants (HCA), five registered nurses (RN) and three activities assistants, two housekeepers, one kitchen manager and one maintenance and property officer confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Four residents (two rest home and two hospital) and six relatives (three hospital and three dementia care) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice. Staff received training on the Code, last occurring in October 2020.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their enduring power of attorney (EPOA). All residents in the dementia unit have an activated EPOA. Advanced directives are signed for separately. There was evidence of discussion with family when the general practitioner completed a clinically indicated not for resuscitation order. The files in the</p>

<p>family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>hospital and rest home areas had an informed consent signed with this scanned into the electronic system. Separate consent forms had been completed for flu vaccinations.</p> <p>Healthcare assistants and registered nurses interviewed confirmed that 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. Staff working in the dementia unit also stated that they actively engaged with residents to give choice around activities of daily living.</p> <p>The resident files sampled had a signed admission agreement and consents completed.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, e.g. attending local community events and cafes. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaints register includes complaints received, dates and actions taken. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). They are signed off by the facility manager when closed. There is evidence of lodged complaints being discussed in the quality and staff meetings.</p> <p>Six complaints were lodged in 2019 and seven in 2020 (year to date). One of the complaints received during</p>

		<p>June 2020 was made through the district health board (DHB). The complaint was investigated, and no fault was found with the facility. All complaints were reviewed and confirmed adherence to HDC response timelines. A detailed investigation was completed for each complaint. Complainants are given the contact details of HDC if they are not satisfied with the outcome. All complaints in the register (2019, 2020) have been documented as resolved.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service provides an information pack to prospective residents that includes information about the Code, complaints, and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code of Rights. Bi-monthly resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed.</p> <p>Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed there are areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Residents and relatives interviewed confirmed that staff treat residents with respect. Staff could describe definitions around abuse and neglect that aligned with policy.</p> <p>The 2020 satisfaction survey identified 98% of residents were happy with privacy. Contact details of spiritual/religious advisors are available. Staff education and training on abuse and neglect has been provided, last occurring in May 2020.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects</p>	FA	<p>Radius Millstream has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of audit there were no residents who identified as Māori. Staff interviewed were able to demonstrate a knowledge of cultural practises.</p> <p>Māori consultation is available through a representative of the Hukatere Marae.</p>

and acknowledges their individual and cultural, values and beliefs.		
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly case conference team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. The monthly staff (team) meetings and toolbox talks include discussions around professional boundaries and concerns noting that because of the Covid pandemic, some meetings have had to be postponed and toolbox sessions have taken their place.</p> <p>Professional boundaries are discussed with each new employee during their induction to the service. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the healthcare assistants' role and responsibilities. The staff/quality meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the facility manager, clinical nurse manager and RNs confirmed an awareness of professional boundaries.</p> <p>A review of incidents and complaints for 2020 did not identify any evidence of discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>The Radius quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. Policies and procedures have been reviewed and updated at organisational level and are available to staff. Staff meetings and residents' meetings have been conducted. Residents and relatives interviewed spoke positively about the care and support provided. Staff had a sound understanding of principles of aged care and state that they feel supported by the facility manager, clinical nurse manager and nursing staff. There are implemented competencies for HCAs and RNs. There are clear ethical and professional standards and boundaries within job descriptions. The quality programme has</p>

		identified opportunities for improvement and initiatives have been implemented in several areas including prevention and management of skin tears, prevention of urinary tract infections and preventing weight loss in dementia residents.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	CI	Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the health status of residents. Fifteen incidents/accidents sampled confirmed this. Resident/relative meetings are held bi-monthly. The facility manager and clinical nurse manager have an open-door policy. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.
<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>Millstream is part of the Radius Residential Care group. The service provides rest home, hospital (medical and geriatric) and dementia level care for up to 80 residents in the care centre and rest home level care across 19 serviced apartments certified for up to 9 residents. On the day of the audit there were 86 residents 45 rest home including one respite resident, 23 hospital and 18 dementia level residents). All hospital and rest home beds in the care centre are dual-purpose beds. All residents were under the aged related residential care (ARRC) contract. There were no rest home level of care residents in the serviced apartments. These apartments are leased and managed by Radius Millstream.</p> <p>Radius Millstream have business goals for 1 April 2020 to 31 March 2021 related to Radius organisational strategic plans. There are reviews of progress through management reports. The facility manager has been in the role for five years. She is supported by a clinical nurse manager, who has been in the role since February 2018 and an office manager. The regional manager also supports the facility manager in the management role and was present during the days of the audit.</p> <p>The managers 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</p>	FA	In the absence of the facility manager, the clinical nurse manager is in charge with support from the regional manager, registered nurses, and care staff.

<p>in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</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>An established quality and risk management system is embedded into practice. Quality and risk performance are reported across facility meetings and to the regional manager. Discussions with the managers (regional manager, facility manager, and clinical nurse manager/RN) and staff reflected their involvement in quality and risk management processes.</p> <p>Resident and family meetings are bi-monthly with evidence of their active participation. Annual resident and relative surveys were last completed in March 2020 with 31 respondents. Approximately 82% of residents and families who participated in the survey expressed their satisfaction of the expectations of Radius Millstream. The outcome of the survey and analysis report were reported at the quality staff and resident meetings.</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 service's policies are reviewed at a national level by the clinical managers group, with input from facility staff 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. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which are utilised for service improvements. Internal audits are completed as per the audit schedule. Quality results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are implemented where results reflect opportunities for improvements. Corrective actions are signed off when implemented.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. Three trained health and safety officers (including the assistant facility coordinator, HCA, and maintenance staff) were interviewed during the audit. They are supported by two health and safety representatives. 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. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. All new staff and contractors undergo a health and safety orientation programme with evidence sighted of staff and contractors participating in annual health and safety refresher programmes.</p> <p>Falls prevention strategies are being implemented. The physiotherapist assesses all new residents. Re-assessments are completed six monthly and post falls. Interventions to reduce the risk of residents falling</p>

		<p>include (but are not limited to) intentional rounding, clip on movement sensors sensor mats, and perimeter mats.</p> <p>Restraint and enabler use is reviewed at monthly staff and quality meetings.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Incidents are included in the Radius key performance indicators (KPI). There is discussion of incidents/accidents at the monthly staff/quality meetings including actions to minimise recurrence. A review of fifteen incident/accident forms from October 2020 on the electronic system identified that forms are fully completed and include follow-up by a RN. Neurological observations were commenced for eight reviewed unwitnessed falls or suspected injury to the head. Not all neurological observations were completed as per policy.</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. There have been nine section 31 notifications made since the last audit for one stage 3 pressure injury and eight resident aggression events. The service has provided training including dementia, delirium and challenging behaviours during Oct 2020. Care plans sighted included management of individual behaviours.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation, and staff training and development. Nine staff files reviewed (one clinical nurse manager, two RNs, four HCAs, two cleaners) included documentation to confirm a recruitment process was undertaken (interview process, reference checking, police checks). Also sighted were signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates are maintained. Registered nurses are supported to maintain their professional competency. Four of nine registered nurses have completed their interRAI training. The orientation programme provides new staff with relevant information for safe work practice.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. Annual and two-yearly core compulsory topics are scheduled with staff expected to complete a written core competency for each topic (e.g., code of rights, cultural safety, aging process, abuse/neglect, sexuality and intimacy, restraint minimisation, informed consent, communication, accident and incident reporting, infection control, emergency procedures, fire safety, health and safety, food handling, chemical handling, challenging behaviours, continence management). There is an attendance register for each training session and an individual staff member record of training.</p>

		<p>Ten HCAs are employed to work in the dementia unit. Nine have completed their dementia qualification (unit standards 2390, 2391, 23922 and 23923). The remaining HCA has been working in the unit for less than eighteen months and is in the process of completing their qualification.</p> <p>Annual staff performance appraisals are undertaken.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Radius Millstream maintains staffing levels that reflect the needs of the residents in all levels of care. The facility manager and clinical manager work 40 hours per week and are available on-call for any emergency issues or clinical support.</p> <p>There is 24-hour RN cover 7 days a week in the hospital wing with 22 hospital and 15 rest home residents. On morning shift there are six HCA's (three long and three short). On afternoon shift there are five HCA's (three long and two short). On night shift two HCA's support the RN.</p> <p>In the dementia wing there are 18 residents. There are two HCA's (both long) and an activities assistant from 9am to 4pm. On afternoon shift there are two HCA's (both long shifts). On night shift there is one caregiver supported by staff from the hospital wing.</p> <p>In the rest home wing, there are 19 rest home and one hospital residents. On morning shift there is are two HCA's(one short and one long). On afternoon shift there are two HCA's (one long and one short) and on night shift there is one caregiver.</p> <p>Adjoining apartments are staffed independently with rest staff assisting at night for emergencies only. At this time, while there are no assessed rest home residents the apartments are staffed independently, however when rest home residents are admitted there will be 24/7 HCA cover.</p> <p>HCAs interviewed reported that there is sufficient staff rostered to meet the resident needs, and that management do their best to replace unexpected leave.</p> <p>Residents and family members interviewed report there are sufficient staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and</p>	<p>FA</p>	<p>The resident files sampled were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office and password protection with electronic files.</p>

accessible when required.		
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long and short-term admission agreements sighted were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation, and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the 'yellow envelope' transfer system. Communication with family is made.</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 safe medicine management that complies with Ministry of Health medication guidelines. Registered nurses and senior healthcare assistants who administer medications have been assessed for competency on an annual basis. Registered nurses complete syringe driver competencies. Regular and 'as required' medications are delivered in blister packs which are checked by an RN against the medication charts. The blister packs are signed on the back following reconciliation and any errors are fed back to pharmacy. Medications are stored safely in the care centre and the dementia care unit. Healthcare assistants and RNs interviewed were able to describe their role in regard to medicine administration. A medication round observed followed correct procedures. Education around safe medication administration has been provided. Medication fridges were monitored weekly and temperatures were within acceptable limits. The service monitors and records medication room temperatures which evidence they do not exceed 25 degrees. All eye drops, ointments and sprays were dated on opening. All medications were prescribed for the resident and no bulk supply order was held on site. There were three self-medicating residents (two rest home and one hospital level) with self-medication competencies signed by the GP. Medication was stored safely in the resident's rooms.</p> <p>Twenty paper-based medication charts (six dementia, six rest home including the respite resident, and eight hospital). The medication charts reviewed evidenced that all medication documentation has been completed appropriately including charting and administration signing. The effectiveness of 'as required' medications is</p>

		recorded in progress notes. All medication charts had photo identification and the allergy status recorded.
<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>The kitchen staff are contracted by an external catering company. There is a fully functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the kitchen manager works closely with the RNs on duty. The kitchen manager is also informed of any residents who have lost or gained weight where interventions are required, and reports back if there are meals returned to the kitchen.</p> <p>The kitchen staff have completed food safety training. The kitchen manager (chef) and cooks follow a rotating four weekly seasonal menu, which has been reviewed by a dietitian. There is a current food control plan in place which expires on 30 March 2021. The temperatures of refrigerators, freezers, dishwashers, and cooked foods are monitored and recorded electronically. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were satisfied with the quality and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to prospective residents should this occur and communicates this to prospective residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall, the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but not limited to) pain, behaviour, nutrition, falls, mini nutritional assessments, depression scales, and continence.</p>

manner.		
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>The electronic care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All residents had an up to date care plan. Care plan interventions documented were comprehensive and resident focussed, care plans documented updates with acute changes to health status. However, not all care needs were included in the care plans. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the gerontologist, psychogeriatric nurse, wound care nurse and dietitian. The care staff interviewed advised that the care plans were easy to follow.</p> <p>Care plans for dementia residents included management of behaviours and de-escalation techniques. Electronic behaviour monitoring charts are completed as required. The leisure care plan outlines activities that are available for dementia residents over a 24-hour period.</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>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Healthcare assistants interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Individual electronic wound assessment, plans and evaluations were in place for all wounds. Wound monitoring occurs as planned. There are currently 32 wounds being treated; four dementia (two skin tears, one abrasion and one lesion), 13 rest home (one surgical wound, eight skin tears, three unidentified skin conditions, and one laceration) and 15 hospital (five unidentified skin conditions, nine skin tears, and one surgical wound). There were no residents with a pressure injury on the days of the audit. The registered nurses describe the referral process for the wound care nurse and high protein diets provided for residents with wounds. Photos are taken regularly and uploaded to the electronic resident file.</p> <p>An adequate supply of continence products was sighted and the registered nurses described having access to the continence nurse through the DHB.</p> <p>A suite of monitoring forms are available on the electronic system including (but not limited to); weight, vital signs, behaviour monitoring, pressure area care, food and fluid charts, fluid balance charts and wound charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	FA	<p>The activity team comprises of three activities coordinators, all of whom have been employed in the last six months. They are mentored by a diversional therapist from a sister facility. The activity team coordinate the activities programme for all residents. Each resident has an individual activities assessment on admission. Based on this information, an individual activities plan is developed as part of the care plan by the registered nurses with input from the activities staff. Each resident is free to choose whether they wish to participate in the</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>group activities programme or their individual plan. Significant time is dedicated to one-on-one activities. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. The residents' files sampled included activities plans within the care plans that are evaluated at least six-monthly when the care plans are evaluated.</p> <p>The weekly programmes for both areas are developed by the activities team. There are separate planners for the dementia and rest home/ hospital area. The residents in the serviced apartments are invited to attend the activities in the rest home/ hospital area. Activities in the rest home/ hospital areas include (but not limited to); daily exercises, housie, happy hours with entertainment, knitting club, bowls, card games and crafts. Resident meetings occur bi-monthly and age concern facilitate the meeting.</p> <p>Residents in the dementia unit have plans that include activities to manage behaviours over the 24-hour period and staff provide activities when activities staff are not present. Residents and families interviewed commented positively on the activity programme. There is a dedicated activity coordinator for the dementia unit who works 32 hours a week over five days. The weekly planner includes (but not limited to); table activities including jigsaws, games and craft, exercises, walks and group games such as golf, singing, reminiscing. There is a healthcare assistant works for four hours in the evenings. The evening healthcare assistant provides calming activities and supervises the residents in the lounge areas when the other health care assistants are busy with resident cares. These activities include watching a movie, colouring and one on one time</p> <p>There are regular volunteers who visit and assist residents with activities and perform musical activities. There are regular church services held and the local kapa haka group, school and kindergarten children visit the facility. Residents from the dementia unit are invited to attend activities in the rest home/ hospital areas where possible.</p> <p>Van outings occur at least weekly in both units, the activities team have current first aid certificates, two are qualified to drive the van. The van has capacity to accommodate one wheelchair. Residents and relatives were complimentary of the activity programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Any changes to care are updated in the care plan. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The six-monthly case conferences (care plan review meetings) involve input from the RN, GP, and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan, and were involved in the six-monthly case conferences.</p>
<p>Standard 1.3.9: Referral</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the electronic resident files reviewed. The service</p>

<p>To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, physio, dietitian and gerontologist. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and visors are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has two current building warrant of fitness. The care centre building warrant of fitness expires on 13 July 2021, and the serviced apartment building warrant of fitness expires on 15 May 2021. The facility has a number quiet seating areas and large open lounge areas in each unit. There is a full-time maintenance person (interviewed) employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius.</p> <p>The facility has sufficient space for residents to mobilise using mobility aids, including a mobility scooter parking/charging bay. The external area is well maintained. Residents have access to safely designed external areas that have shade. There is an interesting and secure garden for the dementia unit. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. All resident rooms have their own ensuite. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. There are toilets situated close to communal areas.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids including those required by hospital level care residents in the dual-purpose rooms. Residents are encouraged to personalise their bedrooms, which was sighted during a tour of the facility.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are several areas for residents and visitors to use include the main lounge and smaller lounges and separate dining areas in each of the rest home, hospital, and dementia units. The communal areas are easily and safely accessible for residents using mobility aids.</p> <p>There is a separate dining room for the residents in the serviced apartments. The dining room has large doors which open up to a garden area. There were two tables each seating up to six residents. On the days of the audit there was adequate space for residents to move around the dining room</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	FA	<p>There are dedicated housekeeping staff, one of the housekeepers is also responsible for checking and returning the clean laundry to resident rooms. Housekeeping staff have access to a range of chemicals,</p>

<p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility. The housekeepers interviewed were knowledgeable around the extra cleaning chemicals and describe still maintaining the extra cleaning duties around high touch areas.</p> <p>All linen and personal clothing is laundered by an external contractor, who collect and deliver laundry and personal items daily. There is a clear process of handling and storage of clean and dirty laundry to meet infection control standards. There are clearly defined dirty and clean areas and doors in the laundry area. Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. There is a minimum of one first aid trained staff member on every shift and during outings. The facility has an approved fire evacuation plan. Fire drills take place at least six monthly. Smoke alarms, sprinkler system and exit signs are in place. Two generators, gas barbeques and torches are available in the event of a power failure. Emergency lighting is in place, which is regularly tested. A civil defence kit is in place. Supplies of stored water and food are held on site and are adequate for three days. Electronic call bells are evident in residents' rooms, lounge areas, and toilets/bathrooms.</p> <p>The facility is kept locked from dusk to dawn.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The facility is appropriately heated and ventilated. All resident rooms have either large external window with garden views, or doors to the garden areas. The facility is heated with underfloor heating and there is heat pumps installed in the lounge areas.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	<p>FA</p>	<p>Radius Millstream has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPIs. The designated infection control nurse with support from the clinical nurse manager, registered nurses, and the quality management committee (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Radius infection control</p>

<p>infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>programme was last reviewed in June 2020.</p> <p>The service has managed the current Covid-19 pandemic well. There has been ongoing information to all staff around how to manage any case of Covid 19, should there be one, and process put in place as per policy. This has included instructions around visiting at each level, management of staff and use of PPE. There is sufficient PPE on site to manage should this be required for an outbreak including a case of COVID-19 for at least two weeks should this be required. An ongoing screening process is implemented for all staff and visitors including a sign in declaration and temperature check on arrival. Visitors are asked not to visit if they are unwell. Hand sanitizers were appropriately placed throughout the facility. Residents and staff are offered the annual influenza vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator has completed off site training with the CDHB and via health learn in 2020. She has access to ongoing education and resources persons including Radius Infection Control Officer, DHB infection control nurse, GP, and public health.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and</p>	<p>FA</p>	<p>There are Radius infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated.</p>

appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for all staff has occurred on an annual basis. The infection control nurse has completed external infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved Topical toolbox talks are also provided. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have generally been low. Trends are identified and quality initiatives are discussed at staff and quality meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. Systems are in place that are appropriate to the size and complexity of the facility</p> <p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed with the owner/manager and at staff meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. The facility is restraint free. The restraint coordinator (registered nurse) was interviewed during the audit. There were no enablers in use at the time of audit.</p> <p>Staff training is in place covering restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	Adverse events are entered into the resident management system. The policy documents that where there are unwitnessed falls, staff must commence neuro observations for 48 hours. However, on the day audit not all observations had been completed as per policy. Health care assistants ensure registered nurses are advised of all incidents and RN's report that they review residents.	Five of eight neurological observation recordings were not documented at intervals as per policy.	<p>Ensure all neurological observations are completed as per policy</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 Low	The electronic care plans were resident centred. The interventions for the residents in the dementia unit were very detailed, individualised and contained specified de-escalation and distraction techniques. Overall, the interventions for acute needs were documented in the long-term care plans. Not all care needs were documented.	<p>i). One rest home resident did not have interventions documented in the care plan for current wounds.</p>	<p>i). Ensure care plans contain interventions for healthcare assistants around wound care.</p> <p>ii). Ensure side</p>

			ii) There were no interventions around the side effects of warfarin or digoxin for a hospital level resident.	effects of warfarin and digoxin are documented to alert healthcare assistants around these. 180 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Radius Millstream is active in identifying areas for improvement and implementing quality initiatives/projects to improve outcomes for residents. The initiatives implemented in the dementia unit have exceeded the required standard and resulted in an improvement in resident wellbeing.</p>	<p>Millstream staff identified through monitoring of monthly data a high incidence of weight loss for residents in the dementia unit. The service developed an action plan commencing August 2019. The plan included weekly dementia staff meetings where HCA's and RN's contributed to individual resident initiatives including: improving food intake, food and fluid intake monitoring, monthly dietitian reviews and implementing individual supplements, fortnightly weighs, and increased GP involvement. Changes to the dementia menu included providing desserts for all residents in the secure unit at dinner and tea meals, provision of high calorie finger foods evenings and night. Milkshakes and sandwiches were provided for morning and afternoon teas and specific preferred options for at risk residents. The effectiveness of the action plan was reviewed at monthly meetings and identified that there was an immediate and sustained reduction in the loss of weight amongst residents in the dementia unit. Six of eight residents have had no further weight loss since the above measures were introduced.</p>

<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	<p>CI</p>	<p>Radius Millstream has put in place strategies to ensure that residents and family members have opportunities to communicate with each other during the lockdown period of the pandemic as well as initiatives to ensure that all are kept informed of facility and practice changes resulting from Ministry of Health and Public Health directives during the pandemic. The initiatives have exceeded the required standard.</p>	<p>Radius Millstream identified the negative impact the lockdown would potentially have on both residents and families and introduced a number of initiatives to improve communication with residents and families.</p> <p>During the Covid-19 pandemic and lockdown periods, the managers and key staff maintained constant communication with residents and family. This included communicating through memos via email, phone calls, and weekly newsletters. Communication to family and whanau included updates from the facility, explanations of measures in place to prevent Covid-19, residents' wellbeing, activities, highlights of their day and points of interest. Newsletters were sent out weekly during lockdown and have continued monthly since. During the lockdown period the activities team enabled residents to link with family on "video chats" using facetime, WhatsApp or messenger with a link set up specifically for families and friends to book a time to be able to speak to the residents. Video calls, particularly for overseas families have also continued. The facility has continued with this form of contact for "out of town" families and those unable to visit for whatever reason. The response from families interviewed and letters and emails from families concerning the communication provided evidence of the successful strategies put into place.</p>
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End of the report.