Radius Residential Care Limited - Radius Peppertree Care Centre

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 Peppertree Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 22 February 2021 End date: 23 February 2021

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: 59

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 Peppertree is owned and operated by Radius Residential Care Limited. The service provides cares for up to 62 residents requiring rest home and hospital (medical and geriatric) level care. On the day of the audit, there were 59 residents.

This certification audit was conducted against the relevant Health and Disability Services 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.

The service is managed by a temporary roving manager with the recently employed manager currently orientating to her role. They are supported by the Radius operations manager, regional manager, a clinical nurse manager, and a team of registered nurses. Residents, relatives, and the GP interviewed spoke positively about the service provided.

This audit has identified shortfalls around care planning timeframes and interventions.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. 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. 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.

Services are planned, coordinated and are appropriate to the needs of the residents. A facility manager and clinical nurse manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. Quality and risk management programmes are embedded. Corrective actions are implemented and evaluated where opportunities for improvements are identified. Falls management strategies are being implemented. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff that is specific to their role and responsibilities. Ongoing education and training programmes are in place,

which include in-service education and competency assessments. Registered nursing cover is provided 24 hours a day, 7 days a week. Residents and staff reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.

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.

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.

The diversional therapist implements 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.

All meals are cooked on site. A current food control plan is in place. The menu has been approved by a dietitian. 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.

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. Preventative and reactive maintenance schedules are maintained. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible and provide seating and shade. 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 service has documented systems in place to ensure the use of restraint is actively minimised. The facility is restraint free. There were six residents using enablers at the time of the audit. Staff receive regular education and training on restraint minimisation and enabler use.

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-19 pandemic, policies, procedures and the pandemic plan have been updated to include Covid-19. Resource information is easily accessible for registered nurses if lockdown levels change after hours. Adequate supplies of personal protective equipment were sighted during the audit.

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	43	0	2	0	0	0
Criteria	0	91	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Radius Peppertree 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. Interviews with eight care staff; including four healthcare assistants (HCA), three registered nurses (RN) and one diversional therapist confirmed their understanding of the Code.
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	Informed consent processes are discussed with residents and relatives on admission. Written consents are signed by the resident or their enduring power of attorney (EPOA). Advanced directives are signed for separately. There was evidence of discussion with relatives when the general practitioner completed a clinically indicated not for resuscitation order. The electronic resident files reviewed had an informed consent and admission agreements signed and scanned into the electronic system. Healthcare assistants and registered nurses interviewed confirmed that verbal consent is obtained when delivering care. Discussion with relatives identified that the service actively involves them in decisions that affect their relative's lives.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files included information on residents' family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a policy to guide practice, which aligns with Right 10 of the Code. The facility manager leads the investigation of non-clinical and clinical concerns/complaints in consultation with the regional manager/RN and clinical nurse manager. All concerns and complaints are entered into an on-line complaint register. There have been four complaints received in 2021 year to date and three complaints made in 2020. Appropriate action has been taken within the required timeframes and to the satisfaction of the complainants. Complaints forms are visible in the main entrance. Management operates an 'open door' policy. Family and residents interviewed confirmed they are aware of the complaints process and that management are approachable. The complaints procedure is provided to residents in the information pack on entry. One of the complaints received in July 2020 was made through the Health & Disability Commissioner (HDC). The complaint has been investigated and followed up. A letter from HDC on 4 September 2020 stated that there would be no further action to be taken.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. Five residents (two hospital and three rest home level) and five relatives (four hospital and one rest home level) interviewed confirmed that staff respect privacy and support residents in making choices. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. 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.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	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. Young people with disabilities are able to maintain their personal, gender, cultural, religious and spiritual identify. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with HCAs described how choice is incorporated into resident cares.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The Māori health plan policy for the organisation references local Māori health care providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. The managers stated that they are in the process of building relationships with the local marae. During the audit, there were three residents that identified as Māori. One care plan reviewed for a Māori resident confirmed that their cultural needs were assessed and the plan included specific interventions as per the assessment.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out where the resident and/or whānau as appropriate, are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. A review of resident records confirmed that 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.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or	FA	Staff job descriptions include responsibilities. The monthly general staff meetings and toolbox talks include discussions around professional boundaries. 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 HCAs role and responsibilities. Professional boundaries are reconfirmed through education and training sessions and performance

other exploitation.		management if there are any specific issues raised.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	All Radius facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A range of clinical indicator data is collected for collating, monitoring, and benchmarking between facilities. Indicators include (but are not limited to) resident incidents/accidents, resident infections, staff incidents/accidents or injuries. Feedback is provided to staff via general staff meetings. Corrective actions are developed where results do not meet acceptable targets. The Radius eCase electronic resident information (eg, care plans, monitoring charts) has been implemented. Interventions (eg, weight management, falls management strategies, pain management, neurological observations, behaviour management) are all documented using eCase. Annual resident/family satisfaction survey results reflect high levels of satisfaction with the services received. The service has created a culture that is resident-centred. Residents interviewed felt that they played a significant role in the life of the Peppertree 'family' and that their presence at the home was valued.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed of an accident/incident. Fifteen incident forms reviewed identified that family have been notified following resident incidents. Staff are required to record family notification when entering an incident into the system. All adverse events reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. The roving facility manager and clinical nurse manager advised that family are kept informed. Bi-monthly resident meetings and surveys provide residents with an opportunity to feedback on the services provided. There is an interpreter policy in place and contact details of interpreters were available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Radius Peppertree is certified to provide rest home, hospital level (geriatric and medical) and residential disability - physical level care for up to 62 residents. There are 20 rest home beds, 20 dual-purpose beds (located within the 'rest home' wing) and 22 hospital level beds. On the day of audit, there were 29 rest home level and 30 hospital level residents, including 10 hospital residents in the dual-purpose beds. Of the 59 residents, there were four (one rest home and three hospital level) younger persons with physical disabilities (YPD) contracts, one hospital resident on an ACC contract, one hospital resident on a long-term support chronic health conditions (LTS-CHC) contract and one hospital resident on an

		hospital recovery DHB contract. All other residents were under the age-related care contract. The 2020/2021 business plan describes the vision, values, and objectives of Radius Peppertree. Strategic goals under the headings of care leadership and management; finance leadership and management; risk management, business and services, and marketing and promotion are linked to the annual business plan. Goals are reviewed a minimum of three-monthly and the business plan is updated annually. At the time of the audit there was a roving facility manager who had been in the role temporarily since November 2020. A new facility manager who has experience in aged care management for 10 years has been employed and started in the role the week before the audit. The facility manager is supported by a clinical nurse manager who has been in the role since October 2018 and has 30 years clinical experience within aged care. The regional manager visits the service every two months and is readily available at other times. The regional manager was present during the audit. The operations manager was present to support the team during the first day of the audit. The roving facility manager and clinical nurse manager have maintained over eight hours of professional development activities related to managing an aged care facility.
Standard 1.2.2: Service Management 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.	FA	The clinical nurse manager covers during the temporary absence of the facility manager. For extended absences, Radius has interim (roving) facility managers who cover facility manager absences. The regional manager is available on a consultative basis.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the managers (regional manager, roving facility manager and clinical nurse manager) and care staff, reflected staff involvement in quality and risk management processes. Resident meetings are held bi-monthly, and minutes are maintained. An annual resident/relative satisfaction survey was completed in August 2020. Results were collated and discussed with staff and residents. Corrective action plans were implemented for improvement areas required from the survey around the expansion of cultural/spirituality activities with programme and assisting residents to feel fully informed and have input into the decision around their health care. The service has policies and procedures and associated

		implementation systems, 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. 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 is utilised for service improvements. Quality data including accidents/incidents, infection control, audit outcomes are reviewed and reported to the monthly quality improvement/ health and safety meeting. Meeting minutes are available to all staff. Results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are implemented when opportunities for improvements are identified (eg, internal audit results are lower than 95%). Corrective actions are evaluated and signed off when completed. Health and safety policies are implemented and monitored by the health and safety committee who meet monthly. Two health and safety representatives (roving facility manager and HCA) interviewed stated the health and safety committee have representatives from across the services. Risk management, hazard control and emergency policies and procedures are in place. There is a current hazard register in place, which was last reviewed in September 2020. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. New staff and contractors receive an induction to the service including the fire evacuation procedure. Falls prevention strategies are implemented including identifying residents at higher risk of falling and the identification of interventions on a case-by-case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting 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.	FA	There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. They are signed off by the clinical nurse manager when completed. A review of 14 incident/accident reports (nine witnessed and unwitnessed falls, two skin tears and two bruising's), identified that the electronic forms are fully completed and included follow-up and investigation by a RN. Neurological observations are completed for any suspected injury to the head and/or unwitnessed fall. The facility manager and regional manager are able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. Section 31 reports have been completed for one stage 3 and one unstageable pressure injuries both in February 2021 and a VOIP phone system outage for 24 hours (all landlines were diverted to

		facility mobile phones) in 2020. A suspected gastro outbreak (staff) in September 2020 was notified to public health authorities.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files were reviewed (one clinical nurse manager, one RN, four HCAs, one diversional therapist and one maintenance/health and safety representative) that included a recruitment process, including reference checking, police check, signed employment contracts, job descriptions and completed orientation programmes. Annual staff appraisals were evident in seven staff files reviewed with the other staff member new to the service. A register of registered nursing staff and other health practitioner practising certificates is maintained. Completed orientation is on files and staff described the orientation programme. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2020 has been completed and the plan for 2021 is being implemented for Radius Peppertree. There are study days per year to cover the compulsory education requirements. Compulsory topics include a written core competency for each topic (eg, 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. Registered nurses are supported to maintain their professional competency. Five out of nine RNs and the clinical nurse manager have completed their interRAI training. Healthcare assistants are encouraged to complete New Zealand Qualifications Authority through Careerforce. Currently there are four HCAs with level 4 NZQA, 14 HCAs with level 3, six HCAs with level 2 and 11 with level 1 NZQA qualifications.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Staffing rosters were sighted and there are staff on duty to match needs of different shifts. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 56 staff in various roles. The facility manager and clinical nurse manager work 40 hours per week, Monday to Friday. The clinical nurse manager is available on call after-hours for any clinical issues, during her absence the RN is on call. The HCAs, residents and relatives interviewed informed there are sufficient staff on duty at all times. In the rest home/dual purpose beds (29 rest home residents and 10 hospital residents) there is an RN on morning and afternoon shift. The RNs are supported by three HCAs full morning shift and one short

		shift, three HCAs on the full afternoon shift and one short shift and one HCA on the night shift. In the hospital wing (20 hospital residents) there is on RN on duty 24 hours. The RNs are supported by three HCAs on full morning shift and one short shift, three HCAs on the full afternoon shift and one HCA on the night shift. The RN in the hospital on the night shift oversees the rest home/dual purpose beds. The HCAs, residents and relatives interviewed informed there are sufficient staff on duty at all times and there were no concerns.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are 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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident information (electronic) is protected from unauthorised access. Entries are legible, dated and signed by the relevant care staff or registered staff, including their designation.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are policies and procedures to safely guide service provision and entry to services including an admission policy. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager or the clinical nurse manager. 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 admission agreements sighted were signed and dated.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	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 using the electronic transfer form. The facility uses the 'white envelope' (same as the yellow envelope system) transfer system. Close communication is maintained with relatives.
Standard 1.3.12: Medicine Management Consumers receive medicines in	FA	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Registered nurses are responsible for the administration of medications and they complete an annual medication

a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		competency and attend medication education annually. Medication fridge temperatures and medication room temperatures are recorded and within expected ranges. The RN on duty reconciles the delivery and documents this on the signing sheet. Medical practitioners write medication charts correctly and there was evidence of one to three monthly reviews by the GP. Medication prescribed is signed as administered on the pharmacy generated singing chart. There were two rest home residents self-medicating on the day of audit. Competencies were in place and reviewed by the GP three monthly. Standing orders are not used. All 16 paper-based medication charts reviewed had photo identification and allergy status identified.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a fully functional kitchen, and all meals and baking are prepared and cooked on site. A food services manual is in place to guide staff. A current food control plan is in place expiring 27 April 2021. The cooks follow a rotating seasonal menu, which has been reviewed by the company dietitian. All recipes are readily accessible through the organisational intranet. The kitchen staff have completed food safety training. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. All food is stored appropriately and dated. The kitchen was refurbished in October 2020, new equipment has been installed, flooring and workspaces were renewed. Meals are served directly to residents in the rest home dining room adjacent to the kitchen. Meals are delivered in hot boxes to the hospital dining area and resident rooms. 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. Resident likes, dislikes, dietary preferences, modified and special diets are accommodated. Coloured food trays were implemented in October 2020. This easily identifies residents who require different dietary requirements including (but not limited to), gluten free, and diabetic diets. The kitchen manager has subsequently provided a card on the residents' tray outlining their dietary requirements/food restrictions. There is special equipment available for residents if required. The kitchen manager was on leave at the time of the audit, the kitchenhand interviewed was knowledgeable around the dietary requirements of the residents and food handling processes. Residents and the relatives interviewed were complimentary about the quality and variety of food served. A food survey is completed six monthly and results are fed back to the kitchen. A recent initiative has been implemented where the cook asks the residents each day for feedback on the meals provided.
Standard 1.3.2: Declining	FA	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

Referral/Entry To Services 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.		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.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The resident 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, however not always within expected timeframes (link 1.3.3.3). 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 and continence.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. The long-term care plans reviewed were resident centred. Interventions documented support needs and provided detail to guide care. Overall short-term care plans were in use for acute changes in health status, however interventions were not always documented for all acute changes in care. 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 wound care specialist, dietitian, physiotherapist, occupational therapist and mental health team for older people. The healthcare assistants interviewed advised that the care plans were easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify relatives about any changes in their relative's health status. The care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed. Healthcare assistants interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessment, wound management plans and wound evaluation electronic forms are in place for all wounds. Wound monitoring occurs as planned. There are currently 17 wounds (skin tears, abrasions, surgical wounds, chronic ulcers) including one unstageable pressure injury, one stage 2 and one stage 1 pressure injuries. Incident reports were completed for the pressure injuries and a section 31

		notification had been completed for the unstageable pressure injury. There has been GP and wound care nurse specialist input for the chronic wounds. Photos have been taken. Electronic monitoring forms are in use as applicable such as weight, vital signs, and wounds. Behaviour charts are completed for any residents that exhibit challenging behaviours.
Standard 1.3.7: Planned Activities 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.	FA	A diversional therapist is employed 32 hours over five days a week to coordinate the activities programme for all residents. She is supported by an activities assistant who works one day a week and then volunteers hours during the week to go on resident outings. 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. Participation is documented on the attendance register. The residents' files sampled included activities plans within the care plans that are evaluated at least six-monthly when the care plans are evaluated. All residents are free to choose whether they wish to participate in the group activities programme or their individual plan. Significant time is dedicated to one-on-one activities including (but not limited to): sensory sessions where the diversional therapist picks flowers and herbs from the garden for residents to enjoy, reminiscence, hand massages, and nail care. Group activities reflect ordinary patterns of life and include planned visits to the community. A gardening group has been developed where residents participate in planting flower and vegetable beds, and plan hanging baskets. An external volunteer takes care of the bee project (continuous improvement from previous audit). Residents and staff can purchase the honey. Bees continue to be a topic of conversation with residents. The facility is decorated for celebrations including (but not limited to), valentine's day, Chinese New Year, Christmas and Easter. Photos are taken and entered in newsletters. Resident meetings are held bi-monthly, meeting minutes evidence the residents having the opportunity to provide input to the activities plan. A food focus group was formed to have meetings with the cook around food services following feedback from a food services survey. Suggestions were taken on board. There have been no further complaints around food services. Younger residents are supported to be independent accessing community groups, and shopping trips as they choose. The facility activities are open for younger residents to attend as they wish to do so. During the audit, residents of all ages were witnessed being supported to access the community via motor scooters, or relatives and volunteers providing transport to various groups. Van outings occur weekly. Church services are included in the activity planner. Residents and relatives interviewed

		commented positively on the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care-plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Any updates required to care plan interventions following the care plan evaluation in case conference is updated in the care plan (link 1.3.5.2). Leisure (activity) plans are in place for each of the residents and these are also evaluated six-monthly. The case conference reviews involve the RN, GP, resident and relatives if they wish to attend. There is at least a three-monthly review by the GP. The relatives interviewed confirmed that they are informed of any changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the relatives/NOK as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed, and the resident reassessed. Examples of close liaison with dietitians, physiotherapist, mental health services and social workers were sighted in resident files reviewed.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	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 and visible on sluice room walls.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that	FA	The building has a current building warrant of fitness. The building has a number of lounge areas in each unit. There is a fulltime maintenance person employed to address the reactive and planned maintenance programme (not available for interview). All medical and electrical equipment was recently serviced and or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius.

are fit for their purpose.		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. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. There are vacant/in use identifiers on doors. The toilets and bathrooms in the Rimu, Tawa, Bellbird and Kauri wings have been refurbished and plans are in place to refurbish the outstanding toilet and bathroom facilities.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	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 and hospital level rooms. Residents are encouraged to personalise their bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The communal areas include the main lounge and several smaller lounges and separate dining areas in each of the rest home and hospital units. The communal areas are easily and safely accessible for residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and	FA	The facility is cleaned by dedicated housekeeping staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. The housekeeper interviewed was knowledgeable around Covid-19 precautions and practices and described the extra cleaning duties performed. The housekeeping trolley

laundry services appropriate to the setting in which the service is being provided.		is stored in a locked room when not in use and has a lockable chemical box on the trolley. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility. All laundry is done in the on-site laundry by dedicated laundry staff. There was a clear dirty to clean flow. The laundry assistant and housekeeper interviewed were knowledgeable of infection control practices and both have attended chemical training. Residents and relatives interviewed were satisfied with the laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an emergency health management plan is in place including a specific rapid response plan to manage a potential Covid-19 outbreak in the facility. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 20 January 2021. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. All RNs hold a current first aid certificate. The office manager (interviewed) is the lead for emergency management planning and is part of the health and safety committee. There are adequate supplies in the event of a civil defence emergency including, food, water (bottled and header ceiling tanks) and gas cooking (gas hobs and two BBQs). Civil defence cupboards are in three separate areas in the facility. Items include torches, whistles, food, shovel, toilet paper, antiseptic wipes, hypothermia blankets and safety helmets. There are also supplies of outbreak/pandemic and personal protection equipment (PPE) available. First aid kits are available in the facility van, nurses' stations, kitchen, laundry and at reception. There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity. Short-term backup power for emergency lighting is in place.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	General living areas and all resident rooms are appropriately heated and ventilated by heat pumps/air conditioners and panel heaters in the resident rooms. All rooms have external windows that open, allowing plenty of natural sunlight.

Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Radius Peppertree 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 clinical nurse manager is the designated infection control nurse with support from the 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 programme is reviewed annually at an organisational level. The infection control team review the infection control plan during quality and infection control meetings. 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.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The clinical nurse manager is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the quality management team) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. Covid-19 precautions continue when entering the facility. The main entrance only is available for visitors and contractors. All visitors and contractors are required to sign in, complete the wellness declarations and record their temperature. Red and green areas are identified in the case of Covid-19 entering the facility. There are clear instructions and procedures for staff to follow when leaving work and returning to the facility. There were frequent zoom meetings with head office during the lockdown periods.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice	FA	There are Radius infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated.

and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed online infection control training. Extra infection control education was provided for Covid-19 including donning and doffing personal protective equipment, outbreak management, and handwashing. Extra internal audits were completed around housekeeping. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Policies and procedures document infection prevention and control surveillance methods. Definitions of infections and systems are in place that are appropriate to the size and complexity of the facility. Surveillance data is collected and analysed monthly to identify areas for improvement, corrective action requirements and provision of staff education. Internal audits around infection control have been completed. Infection rates have generally been low. Trends are identified, and quality initiatives are discussed at staff and quality meetings. There was a gastroenteritis outbreak in 2019. Logs were maintained, the public health service was notified in a timely manner. The outbreak was well managed and documented. There was a suspected staff outbreak in 2020, where three staff had similar gastroenteritis symptoms. The public health service was contacted, no links were identified, and test results were negative.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. At the time of the audit there were no residents with any restraints and six residents using enablers (all bed rails). The files for three residents using enablers showed that enabler use was voluntary. Assessment, consent form and the use or risks associated with the enabler were evidenced in the resident files reviewed. The use of enablers were linked to the resident's care plans and regularly reviewed. Staff receive training on restraint minimisation and enabler use as part of the compulsory study days. The service has been actively working on the reduction of restraints with the aim of a

		restraint free environment. Two residents with restraints were reviewed at the end of 2020 and alternative strategies, including changing the standard bed to king single bed, which were discussed with the resident's family. Both residents are now restraint free.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	All residents on the ARRC and the LTS-CHC contract have interRAI assessments in place. All residents in the facility have a long-term care plan in place, however, these are not always completed or reviewed within expected timeframes.	i) The long-term care plan had been developed before the interRAI assessment for one rest home and one hospital level resident. ii) The initial interRAI assessment had not been completed for one rest home resident within three weeks of admission.	i) Ensure the interRAI assessment has been completed prior to the long-term care plan. ii) Ensure initial interRAI assessments have been completed within expected timeframes. 180 days

Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	i) There were no interventions documented for two hospital residents with infections (one urinary tract infection and one ear infection). ii) There were no interventions documented for a hospital resident with Methicillin-resistant Staphylococcus aureus (MRSA). iii) There were no documented interventions for a hospital resident with oedema in lower legs and short-term course of anti-diuretics.	i) There were no interventions documented for two hospital residents with infections (one urinary tract infection and one ear infection). ii) There were no interventions documented for a hospital resident with Methicillin-resistant Staphylococcus aureus (MRSA). iii) There were no documented interventions for a hospital resident with oedema in lower legs and short-term course of anti-diuretics.	i-iii) Ensure interventions are documented for all acute changes in residents' needs. 90 days

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.