

Radius Residential Care Limited - Radius Elloughton Gardens

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 Elloughton Gardens

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

Dates of audit: Start date: 4 May 2021 End date: 4 May 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: 71

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

Elloughton Gardens is part of the Radius Residential Care group. The service provides rest home and hospital (geriatric and medical) level care for up to 86 residents. On the day of the audit there were 71 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 facility nurse manager has been in the role for the last year. She is an experienced aged care registered nurse (RN) with a background in aged care management. She is supported by a clinical manager/registered nurse (RN), the Radius regional manager and Radius operations manager. The service continues to have oversight by a temporary manager appointed by the DHB.

Residents, relatives and the general practitioner interviewed all spoke positively about the care and support provided and the improvements made by the management team.

There are systems, processes, policies and procedures that are structured to provide appropriate quality care for residents. Implementation is supported through the quality and risk management programme. Ongoing quality initiatives have been implemented at Elloughton Gardens. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

This audit identified one improvement required around care plan interventions.

Consumer rights

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

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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Entry to the service is managed primarily by the facility manager or clinical nurse manager. There is comprehensive service information available on the levels of care. Initial assessments are completed by a registered nurse. Care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans and worklogs (developed on the electronic resident system) are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process. The general practitioner reviews residents at least three-monthly. There is allied health professional involvement in the care of the residents.

The activity programme is varied and interesting and includes outings, entertainment, and links with the community. Each resident has an individual leisure care plan. The rest home and hospital have an integrated programme.

Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Medications are prescribed and administered in line with appropriate guidelines and regulations.

Meals and baking are prepared on site by a contracted service. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness. There is a reactive and maintenance plan. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy. The service is divided into four wings. Each wing has access to a lounge and dining area. There are a mix of ensuites and communal toilet/showering facilities available. There is sufficient space to allow the movement of residents around the facility using mobility aids. The internal areas are able to be ventilated and heated. The outdoor areas for each area are safe and easily accessible. Cleaning and maintenance 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. There is at least one staff member on duty at all times with a first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has documented systems in place to ensure the use of restraint is actively minimised. The facility is restraint free and there are no residents using enablers. 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.
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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	44	0	1	0	0	0
Criteria	0	92	0	1	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 Elloughton Gardens 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 healthcare assistants, six registered nurses and one diversional therapist confirmed their understanding of the Code. Training has been provided regularly around the Code. All staff have completed training across February and March 2021.
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	FA	<p>Informed consent processes are discussed with residents and families on admission. Consent forms, advance directives, and copies of enduring power of attorney (EPOA), where applicable, were seen on each individual electronic resident database (eCase) in the nine resident files reviewed (two rest home and seven hospital including one under an ACC contract, one long term chronic health, one end of life and one on a mental health contract). There is evidence of general practitioner discussion with family regarding resuscitation, as evidenced in the eCase progress notes. EPOA are activated where required.</p> <p>Healthcare assistants and registered nurses (RNs) interviewed confirmed verbal consent is obtained when delivering care. This was observed as occurring during the audit. Discussion with family members</p>

consent.		<p>identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>All nine resident files reviewed had a signed admission agreement completed on entry to the service.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents 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. An advocate has recently met with residents at a resident meeting to describe what they offer. The resident files included information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. 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.</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>	FA	<p>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 manager. All concerns and complaints are entered into an on-line complaint register.</p> <p>There have been nine complaints received in 2020 (four verbal and six written [email] and one complaint [email] made in 2021 [YTD]). Appropriate action has been taken within the required timeframes and to the satisfaction of the complainants. All complaints were discussed in meetings and corrective actions established where identified. There is documented evidence that the service uses the complaint as a learning opportunity for staff and proactively completes training sessions with staff around all complaints.</p> <p>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.</p> <p>The service currently has two complaints open with the HDC service (one from 2018, one from 2019). The DHB placed the facility under DHB temporary management in December 2018 with a number of recommendations. These recommendations are being implemented and monitored. The temporary manager continues to visit the facility intermittently and completes a formal report to the DHB (last site visit</p>

		<p>and report August 2020). There was a number of specific initiatives implemented following the complaints including establishment of a new management team, upskilling of registered nurses and increased roster hours. The new management team (with support by the organisation) have continued to focus on learning from the complaints, ongoing and regular training for staff including registered nurses, critical thinking exercise, regular toolbox talks and case studies.</p> <p>Discussions with residents and families confirmed that any issues are addressed, and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. Ten residents (five hospital and five rest home level) and five relatives (three hospital and two 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 at the entrance to the facility and throughout. The facility nurse manager and/or clinical 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. The resident survey completed December 2020 identified 97% satisfaction with Rights/dignity/privacy. Monthly resident meetings provide an opportunity to discuss any concerns around 'their Rights'.</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 could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect and that they were very happy with the care provided. 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. Eight HCAs interviewed stated they work as a team and are focused on ensuring respect and dignity of residents. The management team have provided ongoing training to HCAs and RNs regularly through in-services and toolbox talks around delivery of care. All staff have completed training around privacy and dignity February and March 2021. There is one married couple. Interviews with the couple confirmed the support and privacy provided by staff.</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 and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There is an organisational Māori health plan policy that references local Māori health care providers regionally. The service has developed linkage with a local kaumātua. 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. During the audit, there were three residents that identified as Māori. Advised that none of the residents had any specific Māori values or beliefs. Cultural safety/treaty of Waitangi training has been provided to all staff 2020/2021.</p>
<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, are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multi-disciplinary/case conference evaluations 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. The resident survey December 2020 identified 86% satisfaction with meeting cultural needs and 70% satisfaction around meeting spiritual needs. A corrective action plan around meeting cultural needs and another corrective action plan around meeting religious and spiritual needs was implemented. Residents and relatives stated the management team were making an effort to ensure individual culture values and beliefs were also considered. All staff have completed cultural safety training in the last six months.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities and code of conduct. All staff sign a Code of Conduct and a non-disclosure agreement as part of employment. The monthly staff meetings, RN 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 management if there are any specific issues raised. All staff have completed specific training around harassment and coercion in 2020 or 2021.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of</p>	FA	<p>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</p>

<p>an appropriate standard.</p>		<p>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 staff meetings. Corrective actions are developed where results do not meet acceptable targets.</p> <p>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.</p> <p>Annual resident/family satisfaction survey results overall reflect high levels of satisfaction with the services received and this was particularly noted in the December 2020 survey. There is a stable management team and a number of quality initiatives and improvements have been noted since previous audit.</p> <p>One quality initiative implemented by the service was around communication and end of life care. It was identified following feedback from the family of a resident who died, that their international qualified RNs were not comfortable with death and that their dealings with the resident and family after death could be improved. A plan to normalise death included education to RNs on how to deal with a resident who has died, how to talk to families, staff visits to Aoraki Funeral Home, guard of honour for residents transferring to the funeral home. The service has continued to implement a number of training sessions and programmes for HCAs and RNs around caring for residents requiring palliative care. Critical thinking exercises have also been implemented at monthly RN meetings. An RN leadership team has also commenced which includes case studies and reflective learning.</p> <p>All residents and relatives interviewed confirmed the improvements to the service, the excellent support from management and the care provided by staff.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>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. Eighteen 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 facility manager and clinical manager advised that family are kept informed, and they described how this is always reinforced with staff. The monthly resident meetings and surveys provide residents with an opportunity to feedback on the services provided. A corrective action plan was implemented following the December 2020 resident satisfaction survey around information/communication. An internal audit around incident forms included 96.6% outcome with all forms identifying family informed.</p> <p>There is an interpreter policy in place and contact details of interpreters were available.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Elloughton is part of the Radius Residential Care group. The service provides rest home and hospital (geriatric and medical) level care for up to 86 residents. On the day of the audit there were 71 residents. Fourteen residents were at rest home level care and 57 at hospital level care (including three ACC short-stay residents, one long term chronic health, three residents on a mental health contract and three residents receiving end of life care). All rooms are dual-purpose beds and divided across four wings (Grant Williams and Elizabeth) currently operating as hospital only. Elloughton Grange wing is predominantly hospital level care and Mountain view is predominantly rest home level care.</p> <p>Radius Elloughton has been under DHB temporary statutory management since late December 2018. The temporary manager continues to monitor the facility, providing guidance to the management team and the staff and submits update reports to the DHB (noting the last visit August 2020. Reports reviewed for 2020 identified overall comprehensive documentation, stable management team, ongoing training, and continued focus on staffing).</p> <p>Radius has an overall core business/strategic plan 2021-2023 that is measured by financial and clinical outcomes. The strategic plan identifies the vision and values of the organisation. There is an Elloughton Business plan 2021-2022 with six main goals to achieve and report on. The business plan incorporates a quality and risk management programme. The facility manager reports on the goals monthly. The organisation has a philosophy of care which includes a mission statement.</p> <p>The facility nurse manager (RN) has been in the role for the last year and is well trained and experienced in aged care management. She is supported by a clinical manager/registered nurse (RN), the Radius regional manager and Radius operations manager (both organisational managers present during the audit). The clinical manager has been in the role for the last five years. The facility manager and clinical manager have completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>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 also available.</p>
<p>Standard 1.2.3: Quality And</p>	FA	<p>An established quality and risk management system is embedded into practice. Quality and risk</p>

<p>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>performance is reported across facility meetings and to the regional manager. Discussions with the managers (facility manager, clinical nurse manager and regional manager) and care staff, reflected staff involvement in quality and risk management processes. Meetings are held regularly, and for all items and discussion there is an action/outcome required/responsibility and status documented. There are weekly Head of Department meetings.</p> <p>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 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.</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 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/infection control meeting and to the monthly staff meeting and monthly RN meeting. Clinical indicators are benchmarked across Radius and reports provided to Elloughton (monthly) identifies where they sit against other Radius facilities. Action plans have been established where they have been above the benchmark. Currently Elloughton is sitting way below the benchmark for monthly average falls (YTD).</p> <p>A RN leadership team meeting has recently been established which includes case studies. Meeting minutes are available to all staff. Corrective action plans are implemented when opportunities for improvements are identified (eg, internal audit results are lower than 95%). However, Elloughton Gardens also documents improvement notes for all partial attainments identified in internal audits even when the outcome score is above 95%.</p> <p>Resident meetings are held monthly, and minutes are maintained. An annual resident/relative satisfaction survey was completed in December 2020. The overall satisfaction was 91% which was an improvement on the 2019 survey. Results were collated and discussed with staff and residents. Corrective action plans were implemented for improvement areas required from the survey around information/communication, activity programme, meals, cultural needs, spiritual needs and laundry service.</p> <p>Corrective actions are evaluated and signed off when completed. All corrective actions are discussed in meetings. Health and safety policies are implemented and monitored by the health and safety committee who meet three-monthly. The health and safety representative 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 is reviewed regularly at meetings. 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</p>
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		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.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. 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 18 incident/accident reports electronically, identified that the electronic forms are fully completed and included follow-up and investigation by a RN. All incidents documented in eCase link to progress notes and assessment tools. All trigger an incident review follow-up by the registered nurse (sighted for all incidents). All fall related incidents linked to post-fall reviews by the registered nurses. Neurological observations were fully completed (as per policy) for any suspected injury to the head and/or unwitnessed fall (sighted in 13 fall-related incidents reviewed).</p> <p>The facility manager and regional manager are able to identify situations that would be reported to statutory authorities. Section 31 reports have been completed for an unstageable pressure injury (hospital acquired). There was also one section 31 report completed due to RN hour shortage as recommended by the statutory manager. Noting, the service at the time was providing 24/7 RN cover but were not meeting the DHB temporary manager requirements of 66.69 RN hours a day (as recommended in the Staffing Regulations for Aged Residential Care facilities consultation document November 2004).</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>There are human resource management policies in place which includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept.</p> <p>Nine staff files were reviewed (one clinical manager, three RNs, three healthcare assistants, maintenance person and activities coordinator). All evidenced that reference checks were completed before employment was offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientations and competencies were evidenced on staff files. RNs sign a health practitioners' agreement. An employee handbook, code of conduct and non-disclosure agreement is completed by all staff.</p> <p>An annual in-service programme is provided with all compulsory sessions provided annually or biannually. Processes are in place to ensure all staff attend required education. The service has been proactive with their training programme. The compulsory training register identifies that nearly all staff have completed their required training and competencies across the last year. Additional training has been implemented as a result of (but not limited to) clinical indicator outcomes, complaints, internal audits and case studies.</p>

		<p>Toolbox talks are held regularly with staff at meetings and in 2021 have included (but not limited to); fluid balance charts, SBARR tool, decision making, neuro observations, palliative care, end of life, incident reporting, weight monitoring, warfarin therapy.</p> <p>Annual competencies include medication, syringe driver, oxygen therapy, hand hygiene, restraint, wound management, hoist and manual handling. Healthcare assistants are encouraged to complete New Zealand Qualifications Authority through Careerforce. There is a total of 38 HCAs. Currently there are 13 HCAs with level 4 NZQA, 6 HCAs with level 3, 8 HCAs with level 2 and 11 with initial NZQA qualifications. All care staff are encouraged and supported to achieve NZQA qualifications.</p> <p>Overall staff turnover has been low over the last year, however they have lost a few RNs to the DHB last year which has at times put pressure on the service meeting the required RN hours identified by the DHB temporary manager. The service has commenced an initiative around enticing and retaining international qualified nurses (IQN) from leaving to work at the DHB. The service has been proactive in trying to access further registered nursing staff. Currently there are eleven registered nurses employed and five are interRAI trained. All RNs complete annual syringe driver training and competency. All have completed training through the hospice. Online training through HealthLearn (through DHB) is also accessed by the RNs. Registered nurses are completing extra training through meetings around critical thinking exercises and case studies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. There is a full-time facility manager (RN) and clinical nurse manager, who work from Monday to Friday and provide rotating on call cover. Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations within contractual timeframes. Staffing levels have been set by the DHB temporary manager.</p> <p>The facility is split into four wings: the Elizabeth, William Grant, Mountain View and Elloughton Grange wings. Staff rostered in the Elloughton wing are available to assist and provide RN oversight to residents in the Mountain View wing. On night shift all units are staffed as one with two RNs and two HCAs.</p> <p>In the Elizabeth wing, there are 20 residents in total (all hospital level), there is one RN on duty on the morning and afternoon shifts. They are supported by four HCAs (2x 0700 - 1500 and 2x 0700 -1330) on the morning shift and on the afternoon shift (2 x 1500 - 2300 and 2x 1700 - 2100). There is one RN on night shift and one HCA.</p> <p>In the William Grant wing, there are 19 residents in total (one rest home and 18 hospital level) there is one RN on duty on the morning and afternoon shifts; (2x 0700 - 1500 and 2x 0700 -1330) on the morning shift and on the afternoon shift (2 x 1500 - 2300 and 2x 1700 - 2100). There is one RN on night shift and one HCA.</p>

		<p>In the Elloughton wing there are (5 rest home and 13 hospital) there is one RN on duty on the morning and afternoon shifts (shared with Mountain View wing). They are supported by three HCAs (2 x 0700 - 1500 and 1 x 0700 - 1330) on the morning shift and by two HCAs (2 x 1500 - 2300) on the afternoon shift. There is a registered nurse rostered across Elloughton and Mountain View wings on night shift.</p> <p>In the Mountain View wing there are 14 residents (10 rest home and 4 hospital) level care residents. The RN rostered across 24/7 is shared with Elloughton wing. There is one HCA rostered on for the full shift morning and afternoon.</p> <p>Staff interviewed stated that staffing levels were good and that the registered nurses and managers provide good support. Advised that extra hours are always added when acuity levels of residents increase. These are monitored weekly at management meetings. Call bell attendance reports continue to provide good response times and there have been no complaints related to staffing or call bell response times since last audit. The February 2021 call bell attendance audit identified 432 calls over 7 days, 85% were answered less than 2 minutes, and 92% (466 calls) were answered within 5 minutes.</p> <p>The DHB temporary manager requires the service to provide 66.69 RN hours a day (as recommended in the Staffing Regulations for Aged Residential Care facilities consultation document November 2004). Using the organisations staff hours calculator, the total RN hours a fortnight would be 847 hours. Elloughton Gardens has been sitting at 955 hours a fortnight (based on the hours identified by the DHB temporary manager). There have been two reported occasions where RN hours had dropped intermittently but were still above the benchmark across the fortnight. HCA hours are sitting well above the benchmark requirements. To keep the RN hours up, the service is also looking for a further two RNs. They are also planning to appoint a team leader role as resident numbers increase.</p> <p>Interviews with residents and family members identified that staffing levels over the last year have been good and they all reported excellent care and in meeting their needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident 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, and dated by the relevant care staff or registered staff, including their designation.</p>
Standard 1.3.1: Entry To	FA	The service has comprehensive admission policies and processes in place. Residents receive a welcome

<p>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>		<p>pack outlining services able to be provided, the admission process and entry to the service.</p> <p>The facility manager/registered nurse or clinical manager screens all potential residents prior to entry to ensure the service can meet the assessed need and support required. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager. The admission agreement aligns with the requirements of the ARCC. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</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>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. Residents in hospital or on social leave are identified and monitored through the eCase resident database.</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>The medication management policies and procedures comply with medication legislation and guidelines. Registered nurses and level 4 HCAs administer medications and have completed medication competencies and medication education. Registered nurses complete syringe driver training. Medications are delivered in blister packs for regular and 'as required' medications. These are checked against the paper-based medication charts and signed off on the pharmacy record. All medications are stored safely in one of three medication rooms and or in locked trollies in each area. There is daily monitoring of the medication fridge and daily monitoring of the medication rooms air temperatures. Both temperatures were within the acceptable ranges. All eyedrops sighted were dated on opening. There is a hospital stock available which is checked regularly for expiry dates. There was one care resident self-medicating on the day of audit. There was a self-assessment competency completed.</p> <p>Eighteen medication charts (paper-based) reviewed (fourteen hospital and four rest home) met prescribing requirements for regular and 'as required' medications. Photo identification and allergy status had been identified on all charts.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	FA	<p>There is a fully functional kitchen located within the service area of the building. All food and baking is prepared and cooked on site by a contracted service. The kitchen manager (interviewed) visits the site</p>

<p>Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>regularly and supports the on-site cook.</p> <p>The service has a winter and summer menu, which has been reviewed by a dietitian in November 2020. Food is plated in the main kitchen and transferred to resident dining areas by hot boxes. Food served on the day of audit was hot and well presented. Pureed foods, diabetic options, food allergies, likes and dislikes are accommodated. The food service company are responsible for ensuring that all kitchen staff are trained in safe food handling and that food safety procedures were adhered to. The contracting service utilises an electronic system for ordering, monitoring of end-cooked temperatures, hot/cold box temperatures fridge and freezer temperature checks and completion of cleaning schedules. Recipes are accessed online. The chemical provider checks and monitors the performance of the dishwasher. All food is stored appropriately and dated. A cleaning schedule is maintained. The current food control plan expires 30 March 2022.</p> <p>Staff were observed assisting residents with their lunchtime meals and drinks. Diets are modified as required and likes and dislikes are catered to. A resident nutritional profile is developed for each resident on admission in eCase and provided to the kitchen staff. The cook is notified of any changes to resident's dietary requirements.</p> <p>Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Monthly resident meetings and annual surveys allow for the opportunity for resident feedback on the meals and food services generally. The resident satisfaction survey completed December 2020 identified a 65% satisfaction with meals. The service implemented a corrective action as a result of the survey. The kitchen manager attends resident meetings two monthly and consults with individual residents as requested. Residents and the family members interviewed commented positively about the quality and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this decision to the potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p>	FA	<p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Information received from hospital discharge, homecare interRAI</p>

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.		assessments and GP medical notes is used to develop the initial interim care plan within 24 hours. Appropriate assessment tools have been completed on eCase and reviewed at least six monthly or when there was a change to a resident's health condition, in the applicable files sampled. Electronic care plans are developed on the outcomes of these assessments. A resident's life story and activity assessment are also completed for all new residents with these sighted in files reviewed. InterRAI assessments had been completed for new residents (excluding ACC residents) within 21 days and are utilised as part of the six-monthly evaluation of care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	<p>Interim/initial care plans were completed for all residents, however not all initial care plans included interventions to meet all identified needs. Long-term care plans reviewed on the eCase described the support required to meet the residents' goals as identified by the ongoing assessment process. The long-term care plans reflected the outcomes of risk assessment and interRAI assessments however not all care plans were updated following a change on level of care to include all specific interventions for all required interventions. There were care plans developed for specific medical conditions such as diabetes and risk plans. Residents and their family/whānau confirmed they are involved in the care planning and review process. The electronic progress notes evidenced resident/relative involvement in care planning and reviews.</p> <p>The resident file (palliative) reviewed included detailed interventions to meet the resident's individual wishes regarding spiritual and family support during end of life. Planned interventions and the resident's preferences regarding pain management were clearly documented. The resident on a LTS-CHC contract file was reviewed and the care plan included interventions to support current medical needs and lifestyle preferences.</p> <p>Allied health involvement from allied health including the GPs, nurse specialist, physiotherapist and podiatry were involved in long-term care plans.</p>
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>Registered nurses (RNs) and HCAs follow the care plans and report progress against the care requirements each shift. If a resident's health status changes the RN initiates a GP or nurse specialist review. Relatives interviewed stated they are contacted for any changes in the resident's health including accidents/incidents, infections, GP visits, appointments, medication changes and transfers to hospital.</p> <p>Staff have access to sufficient medical supplies including dressings. Wound assessment and care plans, wound review plans and evaluation notes were in place for 15 hospital residents with wounds (skin tears, skin conditions, scrapes, and abrasions). There was one pressure injury (stage one). This was resolved and closed during the audit. There were sufficient pressure relieving devices available including air alternating mattresses, foam booties and cushions. Monitoring charts evidenced two hourly repositioning</p>

		<p>as instructed on the work logs. Care plans described interventions for pressure injury prevention for residents identified as 'at risk'. Staff had received education on wound care and pressure injury prevention. There is specialist nursing wound care management advice through the DHB wound nurse.</p> <p>There are sufficient continence products available and resident files reviewed included a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Electronic monitoring forms are completed and reviewed by RNs daily. Progress to meeting interventions to support acute changes in health are monitored and evaluated daily by RNs. Monitoring charts include bowel charts, blood pressure, weight charts, blood sugar levels, food and fluid charts, fluid balance charts, turning charts, behaviour charts, pain monitoring and neurological observations.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There are two activity coordinators (one full time and one part time two days a week) who provide an activities programme from Monday to Friday each week. The full-time activity coordinator has a current first aid certificate and is completing her DT qualification through Careerforce. There are monthly planners distributed in communal areas and to next of kin. A weekly activities planner with the weeks menu on the flip side is distributed to residents. The programme generally runs from 1000 - 1630. Integrated activities take place in one of several lounges, or in the conservatory and activity areas.</p> <p>The residents each have a social, pastoral and life history assessment completed on admission with help from the family. A care plan is developed with resident-centred goals which is reviewed at least six-monthly. Participation records are maintained in the electronic system. Resident files reviewed have an individual recreational assessment and leisure plan that is evaluated at least six-monthly.</p> <p>The programme includes (but not limited to); exercises – sit and keep fit, quiz, trivia and word games, crafts, armchair travel, table games and puzzles, bingo, knitting groups, walking groups, movies and sing-a-longs and carpet bowls. Room visits, and one-on-one time is spent with residents who choose not to join in with group activities. Where possible, activities are individualised according to resident interests. This includes gardening and enabling specific pastoral care.</p> <p>The van for outings has one wheelchair space. There are regular outings such as scenic drives, other facility visits and outings and café visits. Community visitors include entertainers, family volunteers, church services, visiting kindergarten children and school children and pet therapy. Festive occasions and special events including birthdays are celebrated.</p> <p>Residents and families interviewed commented positively on the activity programme. Residents have the opportunity to feedback on the activity programme through monthly resident meetings and annual surveys. The resident survey completed December 2020 identified 79% satisfaction. A corrective action plan was initiated following the survey.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial interim care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plans and summary care plans are evaluated at least six-monthly. A six-monthly multidisciplinary case conference is held (MDT) involving input from resident (as appropriate), relative, care staff, physiotherapist, GP, and other allied health professionals involved in the care of the resident. There is a record of the MDT meeting which records if the resident goals have been met or not. There is at least a three-monthly review by the GP.</p>
<p>Standard 1.3.9: Referral 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>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on electronic resident files. The nurses with support from the clinical manager initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs and responded to in a timely manner. Referrals and options for care were discussed with the family as evidenced in interviews and eCase medical notes. There is close liaison and good communication with dietitians, physiotherapists, podiatrist, mental health service for the older person, assessment and rehabilitation team, ophthalmology, diabetes service and the DHB rest and recuperation team which was sighted in electronic resident files reviewed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Both sluice rooms have keypad locks to prevent unauthorised access. Gloves, aprons, and goggles 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. Staff have completed chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible</p>	FA	<p>The building has a current building warrant of fitness that expires 1 May 2022. The building has a number of alcoves and lounge areas. The maintenance person is employed full time and is available as required after hours. Repairs and maintenance requests are generated through the eCase maintenance log, which is then actioned and logged. Monthly planned maintenance is completed as per the planned maintenance schedule including building warrant of fitness checks. All clinical equipment and electrical equipment is</p>

physical environment and facilities that are fit for their purpose.		tagged, tested and calibrated annually. Hot water temperatures are monitored monthly and are maintained between 43-45 degrees Celsius. The maintenance person described a regular flushing of the hot water system and monitoring of the water due to a history of legionnaires. This has been well managed. Essential contractors are available 24 hours. The facility has sufficient space for residents to mobilise using mobility aids. Residents have access to external areas that have seating and shade. There is an outdoor designated resident smoking area. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.
<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	Two wings have full ensuite services in all bedrooms. The two older wings have either a shared ensuite or toilet facilities only. One room does not have but is located in close proximity to communal facilities. There are adequate numbers of communal toilets and showers 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.
<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	All resident rooms are single. The rooms are of an appropriate size to allow for the safe use and manoeuvring of mobility aids and hoists. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<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	There is an open plan communal lounge and dining room in the Elizabeth wing which is large enough to cater for rest home or hospital residents. There are lounges in each of the four wings and smaller lounges throughout the facility available for quiet areas and family visiting. The lounges are spacious and able to accommodate equipment and provide appropriate areas for dining, relaxation and activities. Activities can also be provided from a separate activities room located adjacent to the large communal conservatory.

<p>Standard 1.4.6: Cleaning And Laundry Services</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>FA</p>	<p>A contracted service is responsible for all communal linen. Soiled linen is collected in bags from an external service area and returned daily to linen cupboards throughout the facility on weekdays. There is a well-appointed laundry with facilities to manage all personal laundry on site. The laundry has defined dirty/clean areas.</p> <p>Staff have access to a range of chemicals, cleaning equipment and protective clothing and receive training in chemical safety. Chemicals are stored safely in trolleys and locked in designated rooms when not in use. Bulk chemicals are stored in an external locked cupboard in the service area. Safety datasheets and product information is available.</p> <p>Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility and the laundry service. The last laundry service internal audit (April 2021) received a 98% outcome. The last cleaning audit (March 2021) was 98% with an improvement note implemented. The resident survey completed December 2020 identified 78% outcome for the laundry service. The service implemented a corrective action around improving 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 management plan and manuals to guide staff in managing emergencies and disasters. All registered nurses are first aid trained. Emergency training is included in the mandatory in-service programme. Elloughton Gardens has an approved fire evacuation plan dated 27 September 2016. A fire drill is completed six-monthly and was last held 20 January 2020.</p> <p>Smoke alarms, sprinkler system and exit signs are in place. A gas barbeque and torches are available in the event of a power failure. Emergency lighting is in place. A civil defence kit is well stocked, checked monthly and stored on the second floor of the front building. Four thousand seven hundred and fifty litres of stored water is available in tanks. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are available.</p> <p>Electronic call bells were evident in resident's rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service completes regular call bell audits. The last audit January 2021 identified only 8% of call bells not answered within 5 minutes. The last resident survey December 2020 identified 71% satisfaction with call bell responses. The service implemented a corrective action following this.</p> <p>The service has a visitors' book at reception for all visitors, including contractors, to sign in and out. There are security policies around locking of the facility from dusk to dawn and all external doors are alarmed. Access by public is limited to the main entrance.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and all resident rooms are appropriately heated and ventilated. Heat pumps are used in communal areas. Resident rooms in William Grant and Elloughton wings are heated by radiators and Mountain View by underfloor heating connected to a boiler system. Elizabeth wing uses electric ceiling heaters. All rooms have external windows that open allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Radius Elloughton Gardens 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 manager is the designated infection control nurse with support from the quality management committee (infection control team) and the organisational infection control coordinator at head office. Infection control and surveillance data is covered in all meetings. 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.</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.</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>	FA	<p>The clinical 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 has completed regular external IC training. The IC nurse and IC team (comprising the quality management team) has good external support from IC nurse specialist at the DHB and IC coordinator at head office. 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.</p> <p>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</p>

		the facility. There were frequent zoom meetings with head office during the lockdown periods.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	There are Radius infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated.
<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	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. Other training has included (but not limited to) isolation procedures. All staff have completed IC and hand hygiene training between November 2020 - March 2021. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
<p>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	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, RN and quality meetings. Infections are benchmarked across the Radius organisation and reports provided. Radius Elloughton remains under the Radius benchmark for number of infections in 2021. The number of antibiotic and prophylactic antibiotics are also monitored monthly and collected as

		part of surveillance.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. 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 no residents using enablers. The service has been restraint-free since August 2020. Staff have received regular training on restraint minimisation and enabler use. Restraint competencies are completed annually. A restraint internal audit is completed annually and was last completed February 2021- 97%. There is an organisational restraint committee that reviews restraint-use across the organisation.</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 1.3.5.2</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	<p>Long-term care plans were documented by a registered nurse. All residents who required a either an interim/initial care plan or long-term care plan had one in place. Healthcare assistants were knowledgeable about the individual resident care needs and progress notes documented all implemented cares. Seven of nine care plans reviewed documented the resident health conditions and current interventions to support all assessed needs. This has been assessed as a low risk as staff were knowledgeable about current cares, and monitoring charts and progress notes evidenced all required cares and interventions were being implemented.</p>	<p>(i) The ACC resident electronic care plan reviewed did not reflect the risk and interventions required to support a recent injury. This resident who required assistance with a prosthesis and daily placement of a splint did not have this documented in the care plan. (ii) One hospital resident's care plan was not updated following a change in assessed level of care on return from hospital to include interventions to manage a change in mobility, falls risk and pressure injury risk.</p>	<p>(i) Ensure interventions are documented to meet all assessed needs. (ii) Ensure interventions are updated to support changes in assessed level of care and reflect the residents' current assessed needs.</p>

				90 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, there 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.