Radius Residential Care Limited - Radius Lexham Park

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 Lexham Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 June 2021 End date: 2 June 2021

Proposed changes to current services (if any): One converted room was assessed as suitable for dual purpose level of care. Twelve rest home resident rooms were assessed as suitable for dual-purpose level of care. This brought the total number of dual-purpose beds available to 64 (including one dual purpose double room).

Total beds occupied across all premises included in the audit on the first day of the audit: 56

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 Lexham Park is owned and operated by Radius Residential Care Limited. The service provides rest home and hospital care for up to 64 residents. On the day of the audit there were 56 residents. As part of this audit, twelve rest home beds and one converted resident room were verified as suitable for rest home or hospital level of care.

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

The service is managed by an experienced manager/registered nurse who has been in the role 13 years. She is supported by a clinical manager and regional manager. Residents and relatives interviewed spoke very positively about the care and the services provided at Lexham Park.

There were no areas for improvement identified at this audit.

The service has achieved continuous improvement ratings for community links, good practice, waste management and restraint minimisation.

Consumer rights

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

Radius Lexham Park practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights 'the Code' and copies of the code are displayed throughout the facility. There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents, and family confirmed the service is respectful of individual needs, including cultural and spiritual beliefs. There are implemented policies to protect residents from discrimination or harassment. There is a complaints policy supporting practice and an up-to-date register. Staff interviews confirmed an understanding of the complaint process.

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.

There are organisational-wide processes to monitor performance and compliance against regulations and legislation required. The service is managed by appropriately trained personnel and there is regional support and a manager in place to oversee service delivery in the absence of the manager. There is an adverse event reporting system implemented. Monthly data collection and analysis is undertaken, and results are made known to staff. There is a human resource manual to guide practice. Staff files reviewed had all employment documentation in place. There is a documented rationale for staffing the service. There are sufficient staff on duty to meet the needs of the residents. Resident information is kept confidential.

Continuum of service delivery

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

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 demonstrate service integration and are reviewed at least six-monthly. Resident files included medical notes by the contracted general practitioner 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. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals.

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

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are all single rooms with hand basins; two have ensuites and the rest share toilets and showers. External areas are safe and well maintained with shade and seating available. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services. There is a first aid trained staff member on duty at all times.

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

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were no residents with restraints and five enablers in use at the time of audit. All appropriate documentation was in place.

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.

There are infection control management systems in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. The infection control coordinator has attended external education. 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. 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. There is sufficient personal protective equipment available. There have been no outbreaks.

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	4	41	0	0	0	0	0
Criteria	4	89	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Radius Lexham Park has an implemented code of rights policy and procedure. Discussions with staff including four healthcare assistants (HCA), three registered nurses (RN), one diversional therapist and one cook also one regional manager, one clinical manager (CM) and one facility manager, identified their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights 'the Code'. Interviews with six residents (two rest home and four hospital) and eight relatives (three hospital and five rest home) confirmed services are provided in line with 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	FA	The service has in place a policy for informed consent. Completed general and advance directive forms were evident on all resident files reviewed (two rest home and six hospital including one young person with a disability (YPD), one ACC, and one long term chronic health condition [LTS-CHC]). Discussions with staff confirmed that they are familiar with the requirement to obtain informed consent for entering rooms and personal care. When interviewed families and residents stated that informed consent was discussed with them on admission and consent forms were signed. Enduring power of attorney (EPOA) is filed in residents' charts.

informed choices and give informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	There is an advocacy policy and procedure that includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy and advocacy pamphlets are available at reception. Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry. The resident file includes information on resident's family/whānau and chosen social networks. There are six monthly family meetings with guest speakers such as Health Consumer Service who provide information on the code of rights.
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.	CI	The residents, family and staff are very involved in community events and functions. Interviews with residents and relatives confirmed that visiting can occur at any time and the residents are encouraged to maintain former community links. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and procedure states that clients/family/whānau shall have access to a complaints system whereby they can express concern without prejudice and those concerns are addressed. Complaint's information and forms are included in the information pack provided to residents and relatives at entry. Residents/family interviewed were aware of the complaints process and stated the management team were approachable should they have any concerns. The manager/RN is the privacy officer and has completed online Privacy Commissioner training. All verbal and written (including email) complaints have been acknowledged, investigated, and resolved to the satisfaction of the complainant within the required timeframes. There is a complaint register that includes date of incident, complainant, summary of complaint, and sign-off as complete. There have been five complaints which was investigated by the regional manager for investigation. Health and disability advocacy was offered, and the complaint closed out with a final letter outlining the investigation and

		outcome for 2021 to date. There have been two complaints to date for 2021.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet, advocacy, and H&D Commission information. The 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. Interviews with residents and relatives identified they are well informed about the code of rights. The Code of Rights (in English and Māori) is displayed in the front entrance.
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	The service has a philosophy that promotes quality of life and involves residents in decisions about their care, respects their rights and maintains privacy and individuality. The admission process identifies the residents advocate or contact person. Discussions with residents and relatives confirmed the staff are respectful and that their privacy is respected, and that cultural and/or spiritual values and individual preferences are identified and met. Spiritual/religious advisors can be accessed for residents on request. Care plans reviewed identified specific individual likes and dislikes. There is an implemented abuse & neglect policy and staff have completed training around this as part of orientation workshop and ongoing as part of the compulsory education planner. Care staff interviewed could describe appropriate practices to prevent and identify any abuse or neglect.
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	There is a specific Māori health care plan and a culturally safe care policy. The service has two residents who identify as Māori. Their cultural wishes are documented within the long-term care plan as viewed. Discussions with staff confirmed an understanding of the different cultural needs of residents and their whānau. The manager is a committee member of the Katikati Community Trust with access to Māori links as required. The service has a memorandum of understanding with Souvenir Tamaki Bluegum who provide local iwi advice and support from kaumātua when required.

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	Care planning includes consideration of spiritual, psychological, and social needs. Residents indicated that they are involved in the identification of spiritual, religious and/or cultural beliefs and felt their needs were being met. Resident care plans for two residents of other ethnicity identified their cultural needs and supports. Care plans reviewed included the residents' social, spiritual, cultural, and recreational needs. There is a visiting chaplain weekly and weekly church services. Relatives interviewed stated that they felt they were consulted. Family involvement in meetings, activities and facility functions is encouraged.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	There is a discrimination and harassment policy in place which is being practiced. There is a staff policy in relation to gifts and gratuities and the management of external harassment. Residents interviewed felt that there was no discrimination. A staff employment orientation package includes a code of behaviour, code of conduct, and a non-disclosure agreement. Job descriptions include responsibilities of the position and ethics, advocacy, and legal issues. The orientation programme provided to staff on induction includes dignity and privacy. Interviews with staff informed an understanding of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	Services are provided at Radius Lexham Park that adhere to the Heath & Disability Services Standards (2008) and all required legislation and guidelines are adhered to. The service has implemented policies and procedures to provide assurance it is adhering to relevant standards. Policies are reviewed and approved by the clinical management committee at an organisational level. The quality programme is designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. Staff are supported to maintain skills and competency through a variety of learning tools including Careerforce, mobile health webinars, health navigation NZ, DHB online learning and DHB study days. The organisation is kept up to date through their aged care membership and RNs have the opportunity to attend quarterly study days. All RNs have a portfolio, for example, wound care, continence, falls, infection control and restraint. The service is proactive in researching ways to improve resident's quality of life such as the introduction of the Feuerstein methodology for residents with cognitive loss.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy for open disclosure. Twenty incident reports reviewed across the service identified the relatives had been notified within a timely manner. Relatives interviewed confirmed they are notified of any changes in their family member's health status. The relatives are invited to the six-monthly care plan evaluations with the RN. Family meetings are held six-monthly in the evenings with invited guests such as presentations on code of rights. Resident and family meetings provide an opportunity for discussion and feedback on the services. Annual surveys are completed. The facility has an interpreter policy to guide staff in accessing interpreter services. There are no residents who currently require an interpreter. The facility can accommodate family who wish to stay with their relative to assist in communication/interpretation where English is their second language. Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The information pack and admission agreement included payment for items not included in the services.
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 Lexham Park is certified to provide hospital services (medical and geriatric) and rest home care for up to 64 residents. This includes one acute primary care bed contracted by the Bay of Plenty DHB. One bathroom converted into a dual-purpose resident room was verified on the day of audit as suitable for dual purpose level of care. The 12 rest home rooms were also verified as suitable for dual purpose. On the day of the audit there were 56 residents. There were 26 rest home residents and 30 hospital level residents including three long-term ACC residents, one younger person and one resident under long-term chronic health condition contract. There was no respite care in the GP bed on the day of audit. There is an overall Radius annual strategic business plan with goals around marketing, risk management, business and services, leadership and management which is reviewed three-monthly. Radius Lexham Park has a 2020-2023 business plan that includes the Radius vision and values. Key performance indicators include falls reduction, increase of survey return rate, refurbishment of bathrooms and carpets and internal audit results above 95%. Review of the business plan, quality plan and action plans are included in the monthly reports to the regional manager (present on the day of audit). The manager is a registered nurse and has been in the role 13 years. She is supported by an experienced clinical nurse manager who has been in the role since October 2020. Notification to HealthCERT for change of manager was sighted. There are long-serving core staff. The manager has maintained at least eight hours of professional development activities related to managing an aged care facility including work safe health and safety, Mini ACE cognitive examination training and psychological first aid (psychosocial impacts of emergencies) in November 2020.

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	During the temporary absence of the manager, the service is managed by the clinical nurse manager with support from the regional manager.
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	There is an organisational quality/risk management plan that includes: clinical/care related risks, human resources, health and safety, environmental/service, financial as well as site-specific risks/goals identified. There are policies and procedures appropriate for service delivery. Policy manuals are reviewed two yearly or earlier due to changes. New/updated policies are sent from head office. New policies/procedures are placed in the staffroom for reading. There are a number of facility meetings including weekly heads of department, two monthly quality risk meeting (includes infection control), two monthly health and safety, RN and enrolled nurse clinical meetings, general staff meetings monthly, and monthly restraint meetings. Quality data including collection of monthly accident/incident, infection surveillance data, resident/relative surveys, internal audits completed and outcomes, reviews of corrective action plans implemented when service shortfalls are identified, occupational health and concerns/complaints are discussed and documented in meeting minutes sighted. Meeting minutes are available in the staffroom. There is an internal audit timetable set up at head office. Internal audits cover the clinical, environmental, health and safety, infection control, support services and human resource areas of the service. Audits are allocated to the relevant person. Monthly audit reports with outcomes are reported to the regional manager. A monthly audit summary is posted in the staffroom and discussed at the facility meetings. Where audit results are less than 95% a re-audit is required. All audits and corrective actions are signed off when completed. A facility health check is completed six-monthly by a regional manager. An external audit was completed February 2021 for the GP primary care bed. There were no corrective actions required by the service. Resident/relative surveys are conducted annually by an external company. Results are collated and fed back to participants. Quality improvement plans are developed for identified areas for improvement. The overall

		performance for 2019 was 78% with a marked improvement in 2020 to 92%. The 2021 overall performance was 85% with cultural and spiritual at 78%. An improvement plan includes developing a focus on Māori culture and church services. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The health and safety committee are representative of management, activities, housekeeping, administration, care staff and maintenance. The health and safety representative (senior HCA) has completed health and safety training. The manager has completed stage 2 of health and safety training. The health and safety committee meet one to two monthly and meeting minutes are available to staff. All staff complete health and safety induction on employment and ongoing as part of the annual training plan that includes emergency management and hazard management. The generic hazard register was reviewed March 2021 and the site-specific hazard register was reviewed by 2020. Contractors complete a site induction. Falls prevention strategies for individual residents such as sensor mats, low beds, landing mats, specialised chairs and intentional rounding are implemented and were described by staff interviewed. Individual care plans identify falls prevention strategies.
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	Twenty incident forms for the month of March 2021 were reviewed including skin tears, falls, and bruises. When an incident occurs the healthcare assistant (or staff discovering the incident) completes the form and the RN undertakes a timely initial assessment. All incidents are logged onto the electronic system and analysed for preventative action. The RN notifies family and GP as required. The clinical manager collects incident reports daily and reviews both the incident and actions taken. The care staff interviewed could describe the process for management and reporting of incidents and accidents. Neurological observations had been completed as per protocol for unwitnessed falls. Discussions with the regional manager and manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. Three notifications have been made since the last audit. One section 31 was completed for a stage 3 hospital acquired pressure injury in May 2021. There were two section 31 notifications for absconding in March and April 2021 for the same resident. There have been no outbreaks to report.
Standard 1.2.7: Human Resource Management Human resource	FA	Eight staff files were reviewed (one clinical manager, two registered nurses, two healthcare assistants, one diversional therapist, one cook and one maintenance person). All files reviewed had appropriate employment documentation including employment contracts, job descriptions, completed orientations and performance appraisals. Practising certificates were sighted for registered nurses, the enrolled nurse, GPs, physiotherapist,

management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		pharmacy, podiatrist, and dietitian. The organisation has a staff orientation policy. The service has developed an orientation folder that is specific to worker type. Orientation workshop days are held that cover site induction including fire safety, emergency management and infection control. Staff interviewed confirmed that all staff employed have an orientation period and that this is extended if required on an individual basis. The service has an internal training programme directed by head office that covers all required topics. There are additional topical tool box talks and reading material. Education sessions are evaluated. There is a register for staff competencies that shows all competencies are current including medications, syringe driver, hand hygiene, and safe manual handling. Qualified nurses have the opportunity to attend external training as offered. Six of six RNs have completed interRAI training. Two RNs are interRAI assessors. The clinical manager is interRAI trained. The clinical manager is a 'smooth mover' trainer for safe manual handling. There are 32 healthcare assistants; 18 have level 4 qualification, seven have level 3 and seven have level 2. There is access to a Careerforce assessor from another local Radius facility.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is an acuity and clinical staffing ratio policy in place that includes a documented rationale for staffing the service. The manager is a registered nurse, works full-time and shares the on-call with the clinical manager. The clinical manager works four days a week and an RN team leader covers the days off. There are 64 dual purpose beds which includes the 12 rest home beds and one converted resident room that were assessed as suitable for rest home/hospital level of care. There were 26 rest home residents and 30 hospital level residents. Staff are allocated on the roster according to resident acuity with the flexibility to extend the shorter shifts as required. There are two RNs on each morning shift and the enrolled nurse works three mornings a week. There is one RN on afternoon shift and one on night shift. Registered nurses are allocated up to three office days a month to complete multidisciplinary team meetings, interRAI assessments, care plans and allocated internal audits. On morning shifts there are 10 healthcare assistants. Six work long shifts from 7 am to 3 pm, three work from 7 am to 1 pm and one works from 7 am to 11 am. On afternoon shifts there are nine healthcare assistants. Four HCAs work the long shift from 3 pm to 11 pm. Five HCAs work short shifts starting at 3 pm with varying finish times between 8 pm to 9 pm. On night shift there are two HCAs. Staff interviewed stated that there is adequate staffing to manage their workload. Staff are replaced for sickness and annul leave.

		Residents interviewed confirmed that there are sufficient staff on duty at all times.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual electronic record and service register. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries in resident files sampled were legible, dated and have an electronic signature by the relevant HCA or RN including 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. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the aged residential care 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. The facility uses the 'yellow envelope' transfer system. Communication with family is made.

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were four residents partially self-administering on the day of audit, for example inhalers. The residents were competent to administer these medications and a consent form had been signed by the resident and GP reviews had taken place. There were no standing orders. There were no vaccines stored on site. The facility uses a paper based and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The RNs administer all medications in the hospital and medication competent HCAs in the rest home. Staff attend annual education and have an annual medication competency completed. Three RNs are syringe driver trained by the hospice. The medication room and medication fridge temperatures are checked weekly, and temperatures meet requirements. Eye drops are dated once opened. Staff sign for the administration of medications on medication sheets. Sixteen medication charts were reviewed (four rest home and twelve hospital). Medications are reviewed at least three-monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.
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	The service has a kitchen manager who works 40 hours a week and a cook who works sixteen hours a week. There are three kitchenhands who work on a rostered basis. There is currently a new chef who is training to take over the kitchen manager role. The kitchen manager and cook have food safety certificates and the kitchenhands have internal training. The kitchen manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen, and all meals are cooked on site. Meals are served in the dining rooms from hot boxes. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the first day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded electronically each day. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. If a resident has weight loss the kitchen manager is notified, and extra protein and supplement drinks are added to the diet. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were satisfied with the meals. The food control plan is due for review on 31 March 2022.
Standard 1.3.2:	FA	The service records the reason for declining service entry to potential residents should this occur and

Declining 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.		communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Prospective 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	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 residents whose files were sampled. The goals identified through the assessment process were linked to care plan interventions. Other assessment tools in use included (but not limited to) pain, behaviour, nutrition, and continence.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs and provide detail to guide care. Care plan interventions are updated for changes in health status. 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 physiotherapist, wound care nurse, dietitian, and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and	FA	When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plan interventions being updated as residents' needs changed. Resident falls are reported on electronic incident forms and written in the electronic progress notes. Neurological

appropriate services in order to meet their assessed needs and desired outcomes.		observations are taken when there is a head 'knock' or for an unwitnessed fall. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessment, wound management and wound evaluation electronic forms are in place for all wounds. Wound monitoring occurs as planned. There are currently nineteen wounds being treated. These consist of five surgical wounds, twelve skin tears, one bruise and one graze. There are currently four pressure injuries including one hospital acquired healing unstageable pressure injury. There is one stage one, and two stage two facility acquired. There has been wound care nurse specialist input. Photos have been taken. Pressure relieving equipment is available and repositioning is documented electronically. Electronic monitoring forms are in use as applicable such as weight, vital signs, and wounds. Behaviour charts are available 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	There is a diversional therapist (DT) who works 32.5 hours a week. There are two activity assistants who work 9 am to 3 pm during the week and 8.30 am to 2.30 pm at weekends. They work on a rostered system. On the days of audit rest home and hospital residents were observed doing exercises, going for a van outing, and playing bingo and bowls. There is a weekly programme in large print on noticeboards and residents have a copy in their rooms. Residents have the choice of a variety of activities, in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits. There are interdenominational church services four times a month. If Catholic residents want communion a priest comes in. There is also a visiting chaplain who comes in every Monday morning. Some residents go out to church. One resident likes to sit at a table in reception and do puzzles. There is a men's group who meet fortnightly. They do projects or go for outings. There are large grounds for residents to walk in. There are weekly van outings. They visit other rest homes to play bowls, go to shops, cafés, and the movies. Sometimes they just go for a drive. Happy hour is every Thursday and there are entertainers. Special events such as birthdays, Easter, Anzac Day, and Queens's birthday are recognised and celebrated. The facility has a cat, and canine friends visit weekly. Visitors also bring in pets. There is community input from a large group of volunteers, child care centres, school groups, brownies, and the RSA.

		The YPD resident is unable to participate in many activities due to illness but still loves music. The ACC resident has an electric wheelchair and goes out into the community independently. The LTS-CHC resident goes into town on his bike. One resident watches the Dutch channel on TV and has Dutch language books. One resident who identifies as Tongan has frequent visits from family and likes to read the Bible. Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career, and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Resident meetings are held two-monthly. Residents and relative interviewed are satisfied with the activities offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All plans reviewed had been evaluated by the registered nurse six-monthly or when changes to care occurred. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP, and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan.
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	Referral to other health and disability services is evident in the electronic resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, mental health services for older people and the physiotherapist. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.
Standard 1.4.1: Management Of	CI	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer’s labels and stored in locked areas. Safety data sheets and product sheets are available. A sharps

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.		container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. Recently the facility and its team have been dedicated to reducing the use of single use plastic items.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness which expires 21 October 2021. There is a maintenance person who works 40 hours a week. There is a contracted gardener for 20 hours a week, but lawn mowing is contracted out. Electrical and plumbing contractors are available when required. There is a preventative and reactive maintenance schedule. Electrical equipment has been tested and tagged. The scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The rest home and hospital are carpeted. Corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. The facility has twelve rest home rooms which were assessed as suitable for dual purpose. These rooms are identical to all the other dual-purpose rooms already certified. The facility has recently converted a bathroom into a bedroom. This room is large enough to accommodate equipment such as shower chairs, hoists, and wheelchairs. It has a shared ensuite, external window and call bell. The converted room was assessed as suitable for dual purpose as well. Staff interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities	FA	All rooms have ensuites, but 29 rooms share their ensuites. Fixtures, fittings, and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs if required. There are privacy signs on all shower/toilet doors.

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.		
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	There is one double room. This room has privacy curtains. All other rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
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	In both wings there are large and small communal areas. The larger areas are used for activities and the smaller areas are for residents to read, entertain visitors or just have quiet time. The dining areas are adequate. There is attractive artwork in the hallways and the communal areas.

Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry is done on site by three laundry workers who work six and a half hours daily. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning and laundry services are monitored. There are two sluice rooms for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms and the laundry are kept closed when not in use. Cleaning trollies have a locked box where chemicals are stored, and they are also stored in the sluice rooms when not in use.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency and disaster policies and plans to guide staff in managing emergencies and disasters last reviewed April 2021. The facility has a fire evacuation plan that has been approved by the fire service 5 September 2002. There are six monthly fire drills last completed January 2021. The manager and maintenance person have completed fire and emergency warden training. All staff completed emergency management training in May 2021. There is a staff member on duty at all times with a current first aid certificate. There are sufficient civil defence supplies in “up and go” bags. There is at least three days of food supplies stored in the kitchen. The kitchen has gas and electric cooking and there are barbeques available. There is a 25,000-litre external water tank of reticulated water on site. Emergency lighting is in place. A generator is hired for emergency power. Electronic call bells are evident in resident’s rooms, lounge areas and toilets/bathrooms. There are security policies around locking of the facility from dusk to dawn. There is security lighting around the facility and solar lighting in the car park.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is	FA	All bedrooms and communal areas have ample natural light and ventilation. There is underfloor gas heating and one wing also has three heat pumps. Staff and residents interviewed stated that both are effective. There is a designated area at the back of the building where residents may smoke. The few smokers have been offered smoking cessation programmes. All other areas are smoke free.

maintained at a safe and comfortable temperature.		
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 Lexham Park has implemented the Radius 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. An RN is the designated infection control nurse since April 2021 with support from the clinical Radius infection control officer at head office. The Radius infection control programme is reviewed annually at organisational level. The service reviews progress towards infection goals at the two monthly infection control committee meetings. Residents are asked not to visit if they are unwell. There was Covid screening and declarations in place. There were adequate hand sanitisers placed throughout the facility.
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 infection control coordinator has completed an aged care study day in May 2021 on Covid Pandemic Planning and has completed a DHB online infection control course. The infection control coordinator is supported by an infection control committee comprised of heads of departments (laundry, housekeeping, food services and maintenance), a RN and HCA who meet two-monthly. The infection control coordinator has access to expertise within the organisation, DHB and aged care membership. There is sufficient personal protective equipment available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training, and education of staff. The infection control policies link to other documentation and uses references where appropriate. Infection control policies are reviewed as part of the policy review process by Radius. Input is sought from facilities when reviewing policies.

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator ensures training is provided to staff through orientation which includes hand hygiene competency and standard precautions and use of personal protective equipment. Infection control training is included in the annual education planner. A Covid taskforce was developed during lockdown to keep staff informed and updated on alert levels and policies and procedures around Covid-19. Radius updates and weekly newsletters were posted for staff. Resident education is expected to occur as part of providing daily cares. Residents and relatives interviewed confirmed they were kept updated in regard to Covid levels, procedures and visiting restrictions.
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	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme. The infection control coordinator maintains a monthly infection control register. This data is analysed for trends and the clinical indicator data is reported to the infection control committee, quality, RN, and staff meetings. The service submits data monthly to Radius head office where benchmarking is completed. There have been no outbreaks since the last audit.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	CI	The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked. The service has remained restraint free which has been retained for the last four years. Currently there were no residents with restraint and five residents with enablers. All appropriate documentation including voluntary consents and reviews were in place. There is a regional restraint group at the organisational level and a restraint coordinator/RN and restraint committee at the facility who meet monthly. Training around restraint minimisation, enablers and challenging behaviour has been provided as part of the orientation for all new staff and ongoing as part of the training plan. Care staff complete restraint competency skills.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.12.1 Consumers have access to visitors of their choice.	CI	The management, staff and residents are actively involved in community functions and hosting local events. Radius Lexham Park is recognised for contributions towards community events and charitable functions and feature regularly in the local newspaper for its participation in the local community.	The service has about ten community volunteers “friends of Lexham” involved in resident activities such as reading and entertainment. The Rotary gifted iPads for residents and a volunteer trainer assisted residents to be able to access internet communication with families and friends. The service hosted a Charitable Christmas concert with funds raised to help a local youngster. Entertainers were involved including choir groups, kapa haka group, a national entertainer and the Lexham Park choir who all performed on a big stage on the front lawn for all residents and community to enjoy. The Uretara native plant nursery grow mature seedlings and small plants on Lexham Park grounds to be planted in community walkways. Residents can be passively involved with the nurse and volunteers who tend to the plants. The annual town mural competition gifted murals for the back fences to brighten up the gardens with garden art. In January 2020, Lexham Park hosted an art exhibition for local artists including resident artists. There was an opening night for the community, residents, family and staff with a wine and cheese evening and artists mingling and talking to guests. Lexham Park residents regularly enter in the API show industry sections and have won highly placed for floral arrangements. Knitters enter the knitted section.

Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	Radius Lexham Park have introduced Feuerstein methodology for residents over the past three years which has had a positive impact on the positivity and empowerment of learning in older adults. The programme was developed in Israel by Professor Feuerstein after the holocaust when faced by a traumatised nation. It is widely used in the classroom and clinical setting.	The service had the opportunity to register residents in 10-week sessions (since 2018) with a qualified Feuerstein educator with an extensive background in teaching. The method teaches students both young and old the art of learning, how to think, how to gather information and how to analyse. The method combines a positivist approach, empowering learners to push beyond their preconceived limits and achieve more than they dared to hope. The most noted outcome with the elderly is a sense of increased validation of life and distinct sense of wellbeing, reduced anxiety and depression, increased independence, which can be lost in old age, and a generally healthier positive outlook. The newest development of the Feuerstein method is the work on the slowing of cognitive degeneration (dementia) by retraining cognitive function. Editorials have been published in the Radius Orbiter and Katikati Advertiser and quote the following from residents “my memory has definitely improved”, “I am now back doing cryptic crosswords something I have not attempted for over three years and that makes me feel much more like my old, younger self”, “I’m feeling more productive and generally happier”. The Feuerstein educator submitted a written paper on the benefits of the programme and submitted this to Adult Education Funding. Further weekly sessions have been funded for Lexham Park residents and day programme participants which will be continued by an understudy trainer.
Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances	CI	Residents have become increasingly concerned at the plastic pollution, which is killing wildlife, devastating oceans and threatening the health of our planet. Through resident discussions and feedback through the activity team; both one on one and in resident forums, residents desired to leave the world in a better place.	Teams were formed, and each team was charged with the responsibility to review current practice and suggest/present alternatives. The teams were made up of residents, families, staff, and management. All aspects of the service were reviewed – clinical, housekeeping, kitchen, and administration. Ideas were shared through weekly newsletters and resident and staff forums. The facility brought in a guest speaker from Waste Free Living. The following are the changes made so far: 1. Plastic teaspoons have been replaced by washable stainless-steel teaspoons. These are used for medication administration from the robotic pack to the resident for ease of administration and swallowing. 2. Small plastic pottles for measurements of liquid medication have been replaced by washable glass measuring utensils. 3. Plastic bags for the collection of used continence products have been replaced by heavy duty brown paper bags. 4. Plastic straws have been replaced by heavy paper straws. 5. Single use plastic aprons used when showering residents have been replaced by washable heavy-duty aprons. This is an ongoing project. There has been an email sent to other Radius facilities and regional managers to share the initiatives that have been tried and implemented. There has also been an article in the Katikati Advertiser supporting the

that complies with current legislation and territorial authority requirements.		Staff agreed and have been enthusiastic to support them.	facility's initiative.
Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	CI	The service has achieved a goal of remaining restraint free for four years through a focus on staff training and managing challenging behaviours.	All care staff receive a resource folder on employment containing the restraint policies, restraint guidelines, risk behaviours, restraint alternatives/de-escalation and restraint methods. Staff complete a self-directive learning package and comprehension quiz to evidence knowledge learned. Annual restraint and challenging behaviours training was last completed April 2021. The restraint coordinator communicates with residents and families on admission regarding the use of restraint and the associated risks. Staff follow guidelines and care plan inventions for the management of behaviours of concern including excluding medical cause of challenging behaviours, confusion and delirium and infection. De-escalation and redirection including the use of activities and one-on-one time has minimised the need for restraint use.

End of the report.