

Radius Residential Care Limited - Radius Waipuna

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 Waipuna
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 1 July 2021 End date: 2 July 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:	77

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 Waipuna is owned and operated by Radius Residential Care Limited. The service provides care for up to 86 residents requiring rest home, hospital, or residential disability level care. On the day of the audit, there were 77 residents.

The service is managed by the operations manager for Radius who is acting in the position of manager, the clinical manager with support from the compliance and risk manager/regional manager. Residents and relatives interviewed spoke positively about the service provided.

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

This audit has identified two shortfalls around monitoring forms.

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 are documented to support resident rights and residents stated that their rights are upheld. Individual care plans include reference to residents' values and beliefs. Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained. Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete these.

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. The service has support from head office that includes the compliance and risk manager. The operations manager for Radius is acting as the facility manager with clinical oversight provided by the clinical manager.

There is a documented quality and risk management programme with key components of the system including management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, and review of risk and monitoring of health and safety, including hazards. Quality data is discussed at facility meetings.

Human resource policies are in place, including a documented rationale for determining staffing levels and skill mixes. A roster provides sufficient and appropriate staff coverage for the effective delivery of care. An orientation and training programme is documented and implemented. 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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The service has assessment processes and residents' needs are assessed prior to entry. There is an admission pack available for residents and families/whānau at entry. Assessments, residents care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in care.

The diversional therapist implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Community links are maintained. There are a variety of activities that are meaningful to the residents.

There are medication management policies in place that meet the legislative requirements. Staff responsible for administration of medications complete annual medication competencies and education. Medication charts have photo identification and allergy status noted. Medication charts are reviewed three-monthly by a general practitioner.

All food and baking is done on site. Resident`s individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

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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There is an emergency management plan to guide staff in managing emergencies and disasters. Six monthly fire drills occur. Civil defence supplies are in place. There were documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current building warrant of fitness. Resident rooms are personalised, and showers are spacious. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating. Communal areas within the facility are easily accessible. The outdoor areas are safe, accessible and provide seating and shade. There is one person on duty at all times with a current first aid certificate. Housekeeping staff maintain a clean and tidy environment. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. The laundry is completed off site.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The restraint coordinator maintains a register. During the audit, there were six residents using restraints. Residents did not use enablers. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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. 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	49	0	1	0	0	0
Criteria	0	100	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Radius Waipuna policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme.</p> <p>Interviews were held during the audit with four managers that included the operations manager (acting facility manager), clinical manager, compliance and risk manager, and the office manager. Staff were also interviewed including the following: four healthcare assistants (HCA), seven registered nurses, the diversional therapist, kitchen manager, owner/director of sub-contracted food services, maintenance staff, and cleaner. All interviewed confirmed their understanding of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their enduring power of attorney (EPOA) sign written consents. Advance directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p>

<p>informed choices and give informed consent.</p>		<p>Nine resident files sampled (six hospital including two YPD, and three rest home) had a signed admission agreement and consents.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Residents on the young persons with disability (YPD) contract are engaged in a range of diverse community activities including regular visits to the local swimming pool. YPD are encouraged and supported to engage in one-to-one and individual activities in the community with many attending social clubs. Van outings are planned more regularly for the younger people with disabilities. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaint register includes written and verbal complaints, dates and actions taken. There were 10 complaints documented in 2020 and seven in 2021 year to date. Three complaints were reviewed, and all showed that an investigation had taken place, timeframes managed, corrective actions put in place when required, and resolutions documented.</p> <p>The Ministry of Health requested a follow-up of three complaints lodged by the Health and Disability Commissioner and one complaint lodged by the district health board. Three of the four complaints were closed. All complaints were around the provision of care. (service provision requirements, assessment, planning, service delivery/interventions and human resource management – staffing/competencies/skill mix and training). This audit has identified issues around service delivery (link 1.3.6.1).</p>

		Discussions with residents and families confirmed that their issues are addressed, and they feel comfortable to bring up any concerns.
<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. There is the opportunity to discuss aspects of the Code during the admission process. Ten residents (three requiring rest home level of care, and six requiring hospital level of care including one who was a young person with a disability [YPD]) and relatives interviewed (four with family at hospital level of care including two with family identified as young people with disability) confirmed that information had been provided to them around the Code.</p> <p>Large print posters of the Code and advocacy information are displayed throughout the facility. The clinical manager, registered nurse (RN) or operations manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed there were 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. There have not been any incidents related to abuse or neglect since the last audit. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>The service has a philosophy that promotes quality of life and involves residents in decisions about their care. 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.</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 a Māori health plan in place for the organisation. Managers identify the Maungakiekie Trust Board Chairperson as the link for local community representation as well as with Waicreate, a local iwi connection for activities external to the facility. The activities team has worked with them to participate in the creation of a waka for example.</p> <p>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. Four residents identify as Maori. Cultural needs are addressed in the care plan.</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 team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries. Staff receive training on cultural awareness.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Policies and procedures align with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.</p> <p>An orientation programme and an annual in-service training programme is implemented as per the training plan with training for registered nurses from the district health board and involvement in the Careerforce programme for all HCAs.</p> <p>There is a minimum of one registered nurse on each shift and residents and family described HCAs as being caring and competent. Residents and family interviewed spoke very positively about the care and support provided and stated the management team are very approachable. The nurse practitioner interviewed also praised the service for care provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p> <p>The service identified improvements since the last audit including painting of the kitchen and external areas, a garden upgrade, replacement of the minivan, a move to an online human resource data system, eCase upgrades (clinical documentation system), management of the service during Covid, and a consolidated education programme.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Eighteen incidents/accidents forms were reviewed. The forms included a section to record family notification. All forms indicated whether the family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.</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>	<p>FA</p>	<p>Radius Waipuna is a Radius aged care facility located in East Auckland. The facility is certified to provide rest home, hospital, and residential physical disability care for up to 86 residents. All beds are dual-purpose. On the day of the audit there were 77 residents including 17 residents using rest home level of care and 60 residents receiving hospital level care. Of the 60 residents at hospital level of care, one resident was under an interim care contract, 12 YPD including one using respite care (all at hospital level), and three under ACC funding. All others were under the Age-Related Care Contract.</p> <p>The 2020 to 2021 and the 2021 to 2022 business plans describe the vision, values, and objectives of Radius Waipuna. Annual goals are linked to the business plan and reflect regular reviews via regular meetings and monthly reports to the regional manager. The business plan for 2020 to 2021 was reviewed prior to the new plan being developed.</p> <p>The operations manager (registered nurse) for Radius is currently the acting facility manager. They have six years' experience of management support providing this to facilities when required, have a diploma in diabetes and over 19 years' experience in aged care. The operations manager was brought into the service in February 2021 to provide support for the new managers. The clinical manager has been in the role for four months. They have had prior experience as a clinical coordinator with a total of six years' experience in aged care.</p> <p>The operations and clinical managers have maintained at least eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures</p>	<p>FA</p>	<p>The clinical manager/RN covers during the temporary absence of the operations manager and the operations manager provides cover for the facility manager when on leave or when they have resigned from the service. The regional manager or facility managers of other Radius facilities are also available.</p>

<p>the provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the managers reflected staff involvement in quality and risk management processes.</p> <p>The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The policies are reviewed at a national level every two years. Clinical guidelines are in place to assist care staff.</p> <p>The quality and risk management 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. Results are communicated to staff across a variety of meetings and reflected actions being implemented in most cases and signed off when completed.</p> <p>There are a range of meetings where data is tabled. This includes a monthly staff meeting, monthly head of department meetings, three monthly restraint meeting, monthly registered nurse clinical meetings and quarterly infection control meetings. There are also resident meetings at regular intervals with family invited to attend. Meeting minutes are documented.</p> <p>Annual resident and relative surveys are completed with results communicated to residents and staff. The 2020 survey completed by residents and family showed an overall satisfaction rate of 80%. The 2021 survey has been distributed but not yet collated.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. Health and Safety representatives have completed level 1 health and safety training from Safety in Action or Work Safe. Health and safety representatives include the office manager, activities coordinator, and maintenance officer with all having completed health and safety training in 2021. Meetings during 2020 were incorporated into the head of department meetings with these changed back in 2021 to health and safety meetings. The operations manager monitors staff incidents (via eCase notifications) on a daily, weekly, and monthly basis and follows their progress proactively and reviews and updates end of month analysis with actions taken if required. The staff incidents, hazards and risk information is collated by the support office, health and safety team and a consolidated report and analysis of all facilities is provided to the board. Trends are identified and appropriate training or upskilling from staff occurs when a trend has been identified.</p>

		Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions.
<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 required.</p> <p>A review of nine incident/accident forms identified that forms are fully completed and include follow-up by a registered nurse. Neurological observations have been carried out two-hourly for any suspected injury to the head (link 1.3.6.1). The clinical manager is involved in the adverse event process.</p> <p>The regional manager was able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents, and unexpected death.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (the clinical manager, one registered nurse, three healthcare assistants, the cook, an activities coordinator and a cleaner) included a comprehensive recruitment process which included reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals.</p> <p>A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. The clinical manager holds overall responsibility for staff education. There is an attendance register for each training session and an individual staff member record of training.</p> <p>Training has been completed by staff post complaints and incidents. This included training around effective communication highlighting open disclosure, the importance of communication with family, clinical discussion regarding documentation of family contact, communication for residents with speech deficits and young people with disabilities, and communication workshops with individual staff follow up. Training has also included post falls education, identification of clinical risk, a person-centred approach, goal planning and strategies to reflect the care needs of individual residents, management of challenging behaviour focused on identification of early warning signs and triggers, nutritional needs for residents with cognitive impairment, abuse and neglect, cultural safety, health and safety, and dignity. There have also been toolbox talks related to care planning, eCase, use of the Sbar tool, and manual</p>

		<p>handling.</p> <p>Registered nurses are supported to maintain their professional competency. Three registered nurses (one is the clinical manager, and one is the facility manager) have completed their InterRAI training. Difficulty accessing interRAI training has resulted in the service being unable to meet all interRAI contractual obligations. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies. There are 45 HCAs and they have completed the following Careerforce training: nine with level 1, three with level 2, 12 with level 3 and 21 with level 4. Supported communication and leadership development programmes are in place for HCA and RN teams (commenced February 2021).</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. Rosters implement the staffing rationale. There are three RNs on site in the morning as well as the clinical manager during week days, and three RNs in the afternoon. There are two RNs overnight. The operations manager (acting facility manager) and the clinical manager take week about for on call.</p> <p>Garden wings include i) Kauri wing with six residents including five at hospital level [one ACC, and one interim care] and one rest home, and ii) Garden View with 26 residents including 16 at hospital level [including eight YPD] and two rest home. There are six HCAs in the morning, six in the afternoon and two overnight. All are rostered onto a full shift.</p> <p>The same roster is in place for the following wings. Tamaki wing with 21 hospital residents [one ACC, one YPD] and seven residents at rest home level; Totara with 11 residents including 10 hospital residents [including four YPD] and one rest home resident; and Kowhai with six residents including three hospital [with one YPD] and three at rest home level of care.</p> <p>While the rosters are the same, there is a high acuity in the Garden view wings with nine of the 12 YPD residents.</p> <p>The other YPD residents and one resident under interim care funding are 'like in abilities as the other residents in the Tamaki wings.</p> <p>Staff working on the days of the audit were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers.</p>
Standard 1.2.9: Consumer	FA	The resident files were appropriate to the service type. Residents entering the service have all relevant

<p>Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>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 files are protected from unauthorised access with password protection for electronic files. Entries are legible, dated and signed by the relevant HCA or nurse, including designation. Individual resident files demonstrated service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are pre-entry and admission procedures in place. All resident files evidenced approval for the level of care by the Needs Assessment Coordinators. The clinical manager liaises closely with the assessing teams to ensure the service can meet the assessed resident needs.</p> <p>The service has a well-presented information booklet for residents/families at entry. Information includes family support programmes and contact details for advocacy to support and younger people with physical disabilities. Four family members interviewed (two YPD and two hospital) stated they received sufficient information on the services provided and were appreciative of the staff support during the admission process.</p> <p>Admission agreements had been signed within a timely manner. Nine admission agreements reviewed aligned with all contractual requirements. Exclusions from the service are included in the admission agreement. Enduring power of attorney activation letters were placed on file where applicable.</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>The transfer/discharge/exit procedures include a transfer/discharge form, and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident. Hospital discharge documentation is integrated in the resident file and care plan.</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 system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. The controlled drug register evidenced a process of reconciliation of controlled drug stock. All medicines are stored securely. Registered nurses and healthcare assistants complete annual medication competencies and medication education. The medication room is near one of the nurses' station. RNs complete the administration of medication; there are five lockable medication trolleys. A recent medication management internal audit was completed with no corrective actions or medication errors/incidents.</p> <p>The RNs are responsible for medication reconciliation against the medication packs for regular and 'as</p>

		<p>required' medications. Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. The medication fridge temperature and medication room temperature are being monitored daily and both were within acceptable limits. There are procedures in place to facilitate safe self-administration of medication for three rest home residents (inhalers). There are no medication standing orders in use. All eye drops were dated on opening.</p> <p>Eighteen electronic medication charts were reviewed. All medication charts had photo identification and an allergy status. The NP/GP reviewed the medication charts at least three-monthly. Prescribed 'as required' medications included the indication for use and the effectiveness was recorded in the electronic system and progress notes. Nutritional supplements are documented and administered from the electronic medication chart.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a large commercial kitchen, and all food is cooked on site. The food service is contracted out to Cibus Catering Limited. There is a comprehensive kitchen manual in place. There is a kitchen manager (qualified chef), and they are supported by two cooks and they are supported by two kitchenhands. There is a seasonal menu in place. The company dietitian has reviewed the menu. The service has a verified food control plan that expires in November 2022.</p> <p>The cook receives a dietary profile for each resident with dietary requirements, special diets, food allergies, likes and dislikes. The kitchen manager interviewed is knowledgeable regarding specific residents needs including those with diabetes, unintentional weight loss (or gain) and recent dietitian input.</p> <p>Alternatives are offered. The cook is notified of any dietary changes for the residents. Food is plated in the kitchen and transported in hotboxes to the dining rooms. The workflow and space in the kitchen is adequate and promotes efficiency. There are three dining areas large enough for residents, mobility equipment and individual wheelchairs. Special diets are plated and labelled. The fridge and freezer have visual temperatures, which are recorded daily on an electronic catering software system. The facility fridges temperatures are monitored (records sighted). Temperature of food on delivery is recorded.</p> <p>The evening meal was observed in the Tamaki and Garden View lounge. The staff assisting residents with their meals promoted and encouraged dining room ambience. There were enough staff to assist with meals in a timely manner and specialised cutlery was available. For residents that may eat slower, food is kept in the hotboxes to maintain the ideal state and temperature of the food, before it was served.</p> <p>Feedback on the service and meals is by direct verbal feedback, as an agenda item at residents and family meetings, and within resident's satisfaction survey. Residents and relatives are satisfied with the</p>

		<p>food choices and meals provided.</p> <p>Staff working in the kitchen have food handling certificates and receive ongoing training.</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>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The RNs complete an initial assessment on admission including risk assessment tools as appropriate. An InterRAI assessment is undertaken within 21 days of admission and every six months. Resident needs, support and goals are identified through the ongoing assessment process and form the basis of the long-term care plan. There were regular pain assessments evident for a resident with complex co-morbidities.</p> <p>Residents interviewed confirmed their preferences and choices are accommodated during their care journey. The information gathered at admission such as allied health notes, needs assessment, discharge summaries and discussion with the EPOA and the resident, is used to develop care needs and support to provide best care for the residents. There are electronic mandatory assessments including initial assessment that covers all activities of daily living and specific assessment tools are used for behaviour, falls risk, nutritional risk, pain assessment and communication tool. The physiotherapist completes an initial mobility assessment for all residents on admission and reviews residents post falls and at least six-monthly. The falls risk assessment tool is repeated for any resident with three falls or more in a month. YPD residents' long-term mobility, seating and postural support needs are assessed with the resident (where able) and their family/whānau.</p> <p>The diversional therapist and other activities staff complete a comprehensive social assessment in consultation with the resident/family.</p> <p>Three YPD resident files reviewed included an individual assessment that includes identifying diversional, motivation and recreational requirements to maintain community involvement and engagement, according to the resident's preference and choice. Behaviour assessments, spiritual and cultural needs had been completed in consultation with the resident and relatives.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The interRAI assessment triggers and scores forms the basis of the long-term care plan. Care interventions are detailed to a level that supports their individual needs and goals. Assessment outcomes were included in the long-term care plans reviewed. The long-term care plan identifies interventions that cover a set of goals including managing medical needs/risks.</p> <p>Alerts on the resident's profile page identify current and acute needs such as (but not limited to); current infection, wound or falls risk. Short-term needs are added to the long-term care plan. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration.</p> <p>Two resident files reviewed (YPD and hospital) had a specific plan for unintentional weight gain. Communication needs are documented for those residents with speech impairments. Staff interviewed were knowledgeable about all individuals in their care and the care approaches they require. Care staff confirmed they have received education in effective communication to manage residents with speech deficits. Staff were also observed in the dining room interacting with the residents in a respectful manner.</p> <p>All files include a 24-hour activity plan and recreational plan with documented individual daily routine. For those residents that present with challenging behaviours; triggers, and activities to distract and de-escalate behaviours are documented with associated risks. There was evidence of allied health care professionals involved in the care of residents including physiotherapist, podiatrist, dietitian, and an occupational therapist. The contracted physiotherapist (8 hours per week) reviews residents for mobility support and seating requirements and will refer if required. The GP/NP, dietitian and allied health professional progress notes were evident in the resident's files sampled. Any change in care required is documented and verbally passed on to relevant staff.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Documentation, observation, and interview with the RNs verified that care provided to the residents is consistent with their needs, goals, and plan of care. The interview with the NP confirmed that discussion and referral to allied health professionals took place in a timely manner. When medical input was required, notification occurred promptly, and any medical orders were appropriately carried out. Family/whānau expressed during interview that assistance was given according to the wishes of their relatives. Specialised equipment including sensor mats, hoists (standing and full), transfer belts, lap belts, pressure relieving mattresses and cushions were available for use. There is a process where equipment (including individualised equipment used by the YPD residents) is checked for safety and maintained by the appropriate services. The service procured recently new equipment including oxygen concentrators, recliner chairs, standing hoist, bariatric hoist, and new slings.</p>

		<p>Continence, wound care products and PPE were in stock for use. Staff received annual education in continence management and wound care management.</p> <p>The wound register was reviewed and current; an updated wound care policy including PI management, and management of skin, nutrition and hydration needs were reviewed. Wound assessment and wound management plans were in place for twenty-six residents (across services). There were two residents with three recorded minor skin tears, four pressure injury (two stage two, one stage three and one unstageable), ten minor skin tears, two lower leg ulcers recorded in the wound register and four skin conditions.</p> <p>Incidence of skin tears are mostly related to the high usage of mobility chairs within the facility; risks are managed accordingly. Wound assessments, plans and reviews are current and completed. Dressings were not always undertaken in the stated timeframes. Registered nurses interviewed were aware of when and how to get specialist wound advice when needed. Monitoring records for (but not limited to) weight, catheter changes, peg changes, food and fluids, blood sugars, behaviours and routine observations (including neurological observations after unwitnessed falls) demonstrated that appropriate care delivering is occurring. Monitoring forms are not always completed in the stated frequency.</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>	<p>FA</p>	<p>The diversional therapist works 40 hours a week and is supported by one activities coordinator who is working towards a diversional therapist certificate. Both are responsible for documentation completion and spends one-on-one time with residents.</p> <p>Care plans acknowledge spiritual and cultural needs. There is an integrated rest home/hospital and separate YPD programme scheduled across six days. Activities are provided between 8.30 am - 5 pm Monday to Fridays and 9 am - midday. Activities coordinators assist with exercise ('sit and be fit', Zumba and tai chi). There are two regular volunteers that assist with various activities.</p> <p>Residents are accompanied to community involvement activities. The activities staff have one-on-one time with residents who are unable or who choose not to participate in the programme.</p> <p>The activities staff at Radius Waipuna provides an activities programme encompassing links to the restorative model of care and enabling strong community links for the residents. The diverse cultures within the facility are incorporated within the programme. A monthly activities calendar is distributed to residents and is posted on noticeboards. Group activities are voluntary and developed by the activities staff in consultation with the residents, healthcare assistants and registered nurses. Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities and is age appropriate. A number of clubs and groups have been initiated by residents including the younger people. Activities are purposeful and focussed to decrease depression, challenging</p>

		<p>behaviour, and mindfulness (word puzzles, memory group). There is evidence of pastoral care though the provision of church services.</p> <p>Activities for younger people are documented to the extent clinically appropriate to reflect the resident's former routines and community engagement, including Māori community links. Residents were involved in making a sculpture of a waka that was unveiled at the Waipuna hotel. There was evidence of engagement with artistic activities, either as an observer or creator. Residents joined in art sessions weekly and created pieces that was put together for an art exhibition within the facility.</p> <p>Special interest groups include a creativity group and art group. Younger people are supported to access community groups/events of their interest including but not limited to RSA and community men's shed.</p> <p>The activity staff completes an initial assessment and resident profile, an activity care plan, and a 24-hour activities plan. Evaluations are completed six-monthly as part of the multidisciplinary team review and complex team meetings. Activities are varied to meet the needs of the groups of residents at the service. The service has a van which is used for resident outings and trips into the community.</p> <p>Residents and relatives interviewed spoke positively of the activity programme with feedback and suggestions for activities made in resident meetings.</p> <p>Residents were observed participating in activities on the days of audit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The initial care plan is evaluated in consultation with the resident/relative and long-term care plans developed. Long-term care plans reviewed had been evaluated six-monthly or earlier for any changes to health. The resident/relative are invited to attend the multidisciplinary review with the clinical manager, RN, healthcare assistants and DT. There is a written evaluation against the resident goals that identifies progression towards meeting goals. Long-term care plans are updated with any changes to meet the resident goals. Short-term care plans were evident for the care and treatment of short-term problems for residents, and these had been evaluated, closed, or transferred to the long-term care plan if the problem was ongoing.</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</p>	<p>FA</p>	<p>Radius Waipuna access other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. There was evidence of referrals to the dietitian, occupational therapist, wound care specialist, continence advisor, ear health nurse, physiotherapy, and the podiatrist.</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are implemented policies in place to guide staff in waste management. Chemicals are stored safely in locked areas. Chemicals sighted were labelled correctly in the original containers, and safety data sheets and product information are readily available to staff. Gloves, aprons, and visors are available, and staff were observed wearing personal protective clothing while carrying out their duties. RNs and healthcare assistants interviewed confirmed enough pandemic supplies are available. Staff have completed chemical safety training and staff could describe the pandemic/outbreak plan of the facility.</p> <p>There are implemented policies in place to guide staff in waste management.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service displays a current building warrant of fitness. The chemical supply company visits each month to check that supplies are adequate, and that staff are managing chemicals safely and efficiently. Audits are performed as part of the internal audit programme as evidenced on the audit schedule reviewed.</p> <p>The service employs a full-time maintenance person who is a health and safety representative. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Essential contractors are available 24 hours. Electrical testing is completed annually. Annual calibration and functional checks of medical equipment is completed by an external contractor. The maintenance person carries out regular checks of transferring equipment, beds, and call bells. The maintenance staff member interviewed has a good knowledge of the responsibilities associated with this role in the organisation. Waste management systems meet legislative requirements.</p> <p>Hot water temperatures in resident areas are monitored. Temperature recordings reviewed, and corrective actions had been taken for temperatures over 45 degrees Celsius.</p> <p>The facility has wide corridors with rails and sufficient space for residents to safely mobilise using mobility aids or for the use of hoists, power chairs and hospital recliners on wheels.</p> <p>There is safe access to the outdoor areas including a children's' playground. All entrances and exits are safe for residents with power chairs, walkers, or wheelchairs. Seating and shade are provided. The healthcare assistants and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is a large ensuite with a wet area shower shared between each two rooms in Kowhai and Kauri wings. There are communal toilets and bathrooms throughout Tamaki and Garden View lounge area. The fixtures, fittings, floors, and wall surfaces are constructed from materials that can be easily cleaned. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Resident rooms have handwashing facilities and are single occupancy. There are sufficient communal toilet/showers to meet the needs of the residents. All communal toilets and showers have appropriate signage and locks on the doors. Fittings, fixtures, and flooring is appropriate. Communal staff and visitor toilets are identifiable and equipped with locks, flowing soap and paper towels. All rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents' rooms are personalised. All residents interviewed confirmed their privacy was maintained while attending to personal hygiene cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are spacious. There is adequate room to safely manoeuvre mobility aids and cater for equipment such as hoists, wheelchairs and fallout chairs and required staff. The doors are wide enough for bed transfer. Residents and families are encouraged to personalise their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are three large lounges with seating arranged to allow residents to mobilise freely. There is a smaller lounge for private and quiet space. Dining areas are spacious to accommodate safe mobility for staff and residents, and for those residents in power chairs. All areas are easily accessible for the residents. Residents interviewed reported they are able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.</p>
<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</p>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. Manufacturer's data safety sheets are available. All linen and personal clothing is laundered off site. Only mop heads are cleaned on site in the laundry.</p> <p>The effectiveness of the cleaning and laundry processes are monitored through internal audits, resident meetings, and surveys. There are dedicated cleaners working across the service. Cleaning trolleys</p>

<p>in which the service is being provided.</p>		<p>are stored safely when not in use. Residents and relatives interviewed were satisfied with the laundry service and cleanliness of the communal areas and their bedrooms.</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>The service has an emergency/disaster/pandemic procedures and manual in place. There is an approved fire evacuation scheme. Fire safety training has been provided. Fire evacuation drills have been conducted six-monthly with the last fire drill occurring on 12 May 2021. There is a staff member with a current first aid certificate on duty 24/7.</p> <p>Civil defence, and biohazard, first aid and pandemic/outbreak supplies are available and are checked on a regular basis. Sufficient water is stored for emergency use and alternative heating and cooking facilities are available. There is a generator available on request if there is a power failure. Emergency lighting is available for back-up. There is an effective call bell system in place. Visitors and contractors sign in at reception when visiting. Security checks are conducted each night by staff. The maintenance manager works full time but is also available on call for building, equipment, and maintenance issues.</p> <p>There is a list of staff and community numbers for emergency contact and an updated evacuation resident list including mobility status of each resident. Night staff complete all security checks.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and all resident rooms are appropriately heated and ventilated. All resident rooms and the communal areas 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>	<p>FA</p>	<p>The Infection Control (IC) programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse has been in the role twelve months (and as a RN for over two years) and has a job description outlining the responsibilities of the role. She is supported by an infection control committee, clinical manager, and the Radius Infection Control Advisor at head office. The infection control programme is discussed monthly and discussed at RN, team, quality and health and safety committee meetings. The IC programme is annually reviewed at an organisational level.</p> <p>There is a Covid-19 prepared plan according to risk levels. Visitors are asked not to visit if unwell.</p>

		<p>There is QR screening and declarations in place for all visitors, staff, and contractors. Hand hygiene notices are in use around the facility and there are hand sanitisers strategically placed throughout the building. Relatives have been kept updated on visiting policies during Covid lockdown and outbreak lockdown by phone calls, emails, and Facebook notices.</p> <p>Residents and staff had been vaccinated against Covid-19. Each resident had a short-term care plan to guide staff in reporting any adverse effects.</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 monthly infection control committee meeting includes representatives from across the services. The committee meet monthly, and data is discussed and published in the monthly minutes and graphs that are available to all staff. The infection control nurse has completed Covid-19 online learning and formal infection prevention and control learning. The service also has access to an infection control and prevention team at the DHB, Public Health, GPs, and local community laboratory infection control team.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There is an infection control manual, which includes policies and procedures appropriate for the size and complexity of the service. Policies are reviewed at head office in consultation with all infection control nurses. Any changes or updates to the infection control policies are notified at staff meetings and are recorded in the staff meeting minutes. There is a Radius Covid-19 policy and outbreak management plan in place.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers,</p>	FA	<p>The infection control nurse is responsible for coordinating/providing education and training to staff. All staff receive infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control hand hygiene competency annually. There has been additional Covid training including weekly meetings, the correct use of personal protective equipment and donning and doffing competencies. There is an infection control focus every month which includes</p>

support staff, and consumers.		in-service.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in Radius Waipuna infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Care plans for the management of infections are added to the long-term care plan. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner. The infection control nurse interviewed reported the service works actively on reducing the high rate of urinary tract infections, at the time of the audit. Reports are easily accessible to the management team and head office staff. A confirmed norovirus outbreak in March/April 2020 that affected 12 residents and five staff was of short duration, managed appropriately and reported to the local public health authority.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. There were six residents using restraints during the audit. There were no residents using an enabler.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. The restraint coordinator in partnership with the RNs, GP or NP, resident and their family/whānau, undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Two hospital level residents where restraint was in use (lap belt and bed rail for one resident and a bedrail for the other resident), were selected for review. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident and family and the GP or NP. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in two resident files where restraint was being used.</p> <p>A restraint register is in place providing an auditable record of restraint use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly as part of the restraint committee meeting. A review of two resident files identified that evaluations are up to date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint minimisation programme is discussed and reviewed at the three-monthly restraint meetings, attended by the restraint coordinator, RNs, and HCAs. Meeting minutes include a review of the residents using restraints or enablers, updates (if any) to the restraint programme, and staff education and training.</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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Registered nurses interviewed confirmed they can easily access policies and procedures and are informed of any changes, however during the interview there were different versions of the frequency of neurological observations. There are a number of monitoring forms used to monitor a resident's health status. Monitoring forms are reviewed by the RN and interventions updated on care plans or short-term care plans developed and reviewed regularly. Not all required monitoring had been completed.	The following shortfalls were identified: (i) Three residents (ACC and YPD) reposition charts were not completed within the frequency stated in the care plan. (ii) Two residents (hospital and YPD) wound dressings were not completed daily as per the wound care plan; and (iii) One hospital resident's neurological observation were commenced but not completed as per the policy for unwitnessed falls.	<p>Ensure monitoring occurs as required.</p> <p>60 days</p>

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.