

Radius Residential Care Limited - Althorp

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: Althorp

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

Dates of audit: Start date: 3 August 2021 End date: 4 August 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: 111

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 Althorp is owned and operated by Radius Residential Care Limited. The service provides care for up to 117 residents requiring rest home, hospital, psychogeriatric and dementia level of care. On the day of the audit there were 111 residents.

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, general practitioner, physiotherapist and a psychogeriatrician.

The service is managed by a facility manager who has experience in aged care management with clinical oversight provided by clinical nurse managers and clinical team leaders. The regional manager provides support for the team. Residents, relatives, a psychogeriatrician and the GP interviewed spoke positively about the service.

This certification audit identified shortfalls around the quality programme, monitoring of care, and to medication management and administration.

A rating of continuous improvement has been given to the activities programme in the secure units.

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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Radius Althorp policies are 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 verified 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 an open disclosure and interpreter's policy that staff understand. Family/friends can visit at any time and interviews verified ongoing involvement with community activity supported. There is a complaints policy supporting practice. Staff interviews confirmed an understanding of the complaints 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.		Some standards applicable to this service partially attained and of low risk.
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Radius Althorp is part of the Radius group and as such, there are organisational-wide processes to monitor performance. Leadership and management is provided by an experienced team.

The quality and risk management programme includes service philosophy, goals, and a quality planner. Quality activities include implementation of an audit schedule, satisfaction surveys, and tabling of data against set indicators. Separate resident and family meetings are held for the dementia unit, psychogeriatric unit and for the hospital/rest home areas. Health and safety policies, systems and processes are implemented to manage risk.

There are staffing policies documented along with a staffing rationale. An education and training programme has been implemented with a current plan in place. An orientation programme is in place for new staff. Appropriate employment processes are adhered to. There is a planned roster that provides appropriate coverage for the effective delivery of care.

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 medium or high risk and/or unattained and of low risk.
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There is an admission pack that provides information on all levels of care. Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. Sufficient information is gained through the initial support plans, specific assessments, discharge summaries, and the care plans to guide staff in the safe delivery of care to residents. The care plans are resident, and goal orientated. Care plans are reviewed every six months or earlier if required. Files reviewed identified integration of allied health and a team approach is evident in the overall resident file. There is a review by the general practitioner at least every three months.

The activities team implements the activity programme to meet the individual needs, preferences, and abilities of the resident groups. The programme encourages integrated activities and community links. There are regular entertainers, outings, and celebrations. Activities are focused on meaningful and sensory activities in the dementia care and psychogeriatric units.

Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior healthcare assistants who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three-monthly by the general practitioner. The psychogeriatrician visits the service fortnightly.

All meals are provided on site by a contracted service. There is a current food control plan in place. Resident dietary needs are met, and alternative foods offered for dislikes. There are nutritious snacks available 24 hours.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan in place. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. Cleaning and laundry services are well monitored through the internal auditing system.

There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas in each wing. The internal areas are ventilated and heated as needed. The outdoor areas are safe and easily accessible. The dementia and psychogeriatric units are secure, and they also have outdoor areas that are freely available for residents to use.

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 for the safe assessment and review of restraint and enabler use. During the audit, there were no residents using restraint and three residents voluntarily using enablers (bedrails). The restraint coordinator reviews enabler use three-monthly.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control nurse (registered nurse) working together with the clinical nurse manager, is responsible for the implementation of the infection control programme including education, internal audits, collation of infection control data and communicating outcomes, trends, and analysis to the clinical/quality teams. There is access to infection control advice and support through expertise within the organisation and DHB.

The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. COVID-19 screening procedures continue for all staff, visitors, and contractors. There is adequate supply of personal protective equipment and hand sanitisers.

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	1	41	0	1	2	0	0
Criteria	1	89	0	1	2	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	<p>There are policies describing the rights with application of the policy described in the training provided to staff. The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their families.</p> <p>Managers were interviewed including the facility manager, clinical nurse manager, regional manager, and the clinical team leader (acting clinical nurse manager). Staff interviewed included six healthcare assistants (HCAs) and seven registered nurses (RNs) with representation from all levels of care; a chef/kitchen manager; physiotherapist, two laundry assistants; two housekeepers; the diversional therapist and an activities coordinator; and maintenance manager. All interviewed were able to describe implementation of the rights relative to the level of care provided to each resident and as per individual wishes.</p> <p>Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme.</p>
Standard 1.1.10: Informed Consent Consumers and where appropriate their	FA	<p>Eleven resident files were reviewed, (one rest home, five hospital level including one resident in a palliative care bed, one ACC resident and one younger person, two dementia level of care and three psychogeriatric level of care). Informed consent processes had been discussed with residents (as appropriate) and families on admission. Written general consents and specific consents (e.g., influenza vaccine consents) were</p>

family/whānau of choice are provided with the information they need to make informed choices and give informed consent.		<p>sighted on the electronic files. Advance care plans where known were available on the resident files.</p> <p>There was evidence of discussion with family when the GP completed a clinically indicated 'not for resuscitation' order where residents were deemed not to be competent. The enduring power of attorney (EPOA) had been activated in the files reviewed of dementia care and psychogeriatric care residents. The registered nurses and healthcare assistants 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>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services is included in the resident information pack that is provided to new residents and their family on admission. Advocacy brochures are also available at reception. Interviews with residents and family confirmed their understanding of the availability of advocacy services.</p> <p>The complaints process is linked to advocacy services with this required to be offered to any complainant if they were not satisfied with the outcome of the complaint. The electronic system includes a tick box to confirm that the complainant is happy with the outcome and a box to tick to confirm that advocacy services have been offered. While four of four complaints reviewed stated on the electronic system that the complainant was not satisfied with the outcome, other documentation, and conversations with one of the complainants confirmed that they were satisfied with the process and outcome. The management was reminded during the audit to complete all tick boxes and complete as required.</p> <p>Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service with training records confirming this.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programmes include opportunities to attend events outside of the facility including activities of daily living, (e.g. attending cafés, and restaurants). Interviews with staff, residents and relatives confirmed that residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends stated that they were encouraged to be involved with the service and care.</p> <p>The main doors lock at dusk. Family are able to ring through to the service using the two main entrances if they wish to visit after hours.</p>
Standard 1.1.13: Complaints	FA	<p>The service has a complaints policy that describes the management of the complaints process. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are</p>

<p>Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>available for residents/relatives in various places around the facility. There is a complaint register that includes relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings (link 1.2.3.6).</p> <p>There have been 15 complaints made in 2020 and nine received in 2021 year to date. Four of four complaints reviewed included follow-up meetings and letters or resolutions within the required timeframes as determined by the Health and Disability Commissioner.</p> <p>One complaint was received in 2019 from the district health board (DHB), Ministry of Health and Health and Disability Commission. The complaint is still open noting that the management team has sent in evidence as requested.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service provides information to residents that includes the Code, complaints, and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident.</p> <p>Eight residents were interviewed (six with hospital level of care (including one young person with a disability [YPD] and one under respite level of care), and two under rest home level of care. Nine relatives were interviewed including five with family under hospital level of care (including two with family under palliative care); one with family in the dementia unit and three with family in the psychogeriatric unit. All stated that they were well informed about the Code. There are resident and family meetings that provide the opportunity to raise concerns. An annual residents/relative survey also offers opportunities to raise concerns.</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>The residents' personal belongings are used to decorate their rooms. Rooms have ensuites and there are communal toilets as well. All have a mechanism or way of determining if the rooms are occupied to ensure privacy.</p> <p>The care staff interviewed report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed to occur during the audit. Healthcare assistants reported that they promote the residents' independence by encouraging them to be as active as possible. All the residents and families interviewed confirmed that residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service. Incidents were reviewed for 2021 and there are no incidents around abuse. Staff, the psychogeriatrician, and the general practitioner interviewed</p>

		<p>confirmed that there was no evidence of abuse or neglect.</p> <p>There are spiritual services and residents are encouraged to attend their own spiritual care in the community if they can. There is at least one church service a week. Any resident or family member can attend. Spiritual needs are individually identified as part of the assessment and care planning process. Residents who wish to attend or residents who staff feel would enjoy the activity from the dementia and psychogeriatric unit were observed to also attend the interdenominational service on the day of audit.</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>Radius Althorp has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of audit there were 10 residents who identified as Māori. Three resident files for those who identified were reviewed and included a Māori health plan. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Māori consultation is available through connecting with local marae and Kaumatua groups from the community. There are specific community activities for Maori. These include the kaumatua and kuia waiata choir with this led by residents who identify as Maori with others encouraged to attend. The DT is fluent in te reo and other staff were observed to use greetings and phrases in Maori. Staff spoke of one resident in the psychogeriatric unit who plays the guitar and engages actively in the activity. Cue cards in Maori are used to prompt discussion with residents who speak te reo as a first language. This was observed to occur in the secure units and in the hospital/rest home units.</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>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family, and/or their representative. Staff interviewed confirmed that they are committed to ensuring each resident remains a person, even in a state of decline with discussion from care staff around the model of person-centred care. Beliefs and values are discussed and incorporated into the care plan as sighted in the review of 11 resident records reviewed (five hospital, one rest home, two dementia, and three psychogeriatric). Residents and families interviewed confirmed they are involved in developing the resident plan of care, which includes the identification of individual values and beliefs.</p> <p>There is one resident who has English as a second language. Interpreting services are available along with family who also support the resident. Discussion with relatives confirmed values and beliefs are considered.</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>There are implemented policies and procedures to protect clients from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries with residents.</p> <p>Residents interviewed stated that they have not experienced any discrimination, coercion, bullying, sexual harassment, or financial exploitation. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and managers state that performance management would address any concerns if there was discrimination noted. Staff also described actively trying to develop a positive culture for people with dementia through talking about this with family and being positive around expectations.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The Radius quality programme is designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility (link 1.2.3.6). Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. Policies and procedures have been reviewed and updated at organisational level and are available to staff.</p> <p>Residents and relatives interviewed spoke very positively about the care and support provided. Communication and liaison between the DHB team and managers has improved with managers confirming that this had occurred. Residents and family stated that communication between them and nursing staff had improved over the past year. A psychogeriatrician visits at least fortnightly and as required and family are notified prior to the visit and invited to attend. The general practitioner (GP) visits twice a week or more frequently if required. The GP practice is dedicated to visiting aged care facilities and is available after hours.</p> <p>Staff had a sound understanding of principles of aged care and stated that they feel supported by the recent input from the regional manager, and the management team. The management team has sound knowledge of specific needs of residents using a variety of levels of care and provide leadership and advice for staff. There are implemented competencies for HCAs and RNs.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p>	FA	<p>Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. There is a pack for potential and new residents and family that includes information around the secure units and the hospital and rest home including differing models of care. Family members interviewed stated they are informed of changes in the health status of residents and 18 of 18 incident forms sampled evidenced that family were informed of an adverse event. Managers have an open-door policy and residents and family stated that they could call at any time with requests followed up of concerns managed.</p>

effective communication.		Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available through the District Health Board with phone numbers identified in policy. There are staff on site who speak a range of languages. There are no residents currently requiring the use of interpreting services.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Radius Althorp is part of the Radius Residential Care Group. The service currently provides rest home, hospital, dementia, and psychogeriatric level care for up to 117 residents. On the day of the audit there were 111 residents. There were three residents requiring rest home level of care; 49 residents at hospital level of care in the dual-purpose unit (including two identified as being under a YPD contract, five under a palliative care contract, one using respite care services, and one under an ACC contract; 30 residents in dementia care (two secure units of 15 beds each); 29 residents in the psychogeriatric units (two secure units of 15 beds each). All other residents were under the age-related residential care (ARRC) contract.</p> <p>The current business plan is linked to the Radius Residential Care Group strategies and business plan targets. The mission statement is included in information given to new residents and family. An organisational chart is in place. Quarterly reviews are undertaken to report on achievements towards meeting business goals. A corrective action plan served as the business plan for 2020 and this has been reviewed prior to the documentation of the current business plan.</p> <p>The facility manager is non-clinical, has been in the role for a year and has 11 years previous experience as a facility manager in other aged care facilities. Support is being provided by the regional manager who was present on the days of audit. The facility manager has attended over eight hours of training relevant to the role in the past year as sighted in the staff file.</p> <p>There are two clinical nurse managers and two clinical team leaders (RNs). One clinical nurse manager has an advanced nursing assessment diploma in health management level 7 and has four years overseas experience as a registered nurse, and a further four years' experience in the role in New Zealand in dementia and psychogeriatric units. The second clinical nurse manager is on leave and the clinical team leader is acting in the role. This clinical team leader has more than five years in the role as clinical team leader and provides leadership in the hospital and rest home units.</p> <p>The clinical nurse manager and clinical team leaders have maintained more than eight hours of professional development activities related to managing an aged care facility and to clinical care.</p>
Standard 1.2.2: Service	FA	In the absence of the facility manager, the clinical nurse manager is in charge with support from the regional

<p>Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>manager and clinical team leaders.</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>	PA Low	<p>The organisational business plan includes quality goals and risk management plans for 2021. This includes targets in all areas including clinical care. There is a Radius organisational risk management plan which is discussed at the health and safety meeting.</p> <p>There is an established the organisation's quality and risk management system. The management team is responsible for implementation of the quality and risk management programme with the facility manager providing oversight of the quality programme. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff. A document control process is well established.</p> <p>The annual residents/relatives survey for the service was last completed in September 2020, results were compared with the September 2019 survey. The 2020 report shows that respondents were more satisfied with all aspects of the survey when compared with the 2019 report, including improved satisfaction in care provided by the RNs, information and communication with managers and clinical staff, rights upheld, family being fully informed and cultural aspects of care. Over 80% of respondents stated that they would recommend the service to friends or family.</p> <p>The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans with evidence of resolution of issues as these are identified. Only two audit reports (one in 2020 and one in 2021) identified a rating less than 96%. The management team stated that they had worked hard to address issues raised previously in other audits prior to those reviewed.</p> <p>Monthly and annual analysis of results is completed and provided to staff and to the support office. There are monthly accident/incident reports that break down the data collected across the different levels of care. Infection control is also included as part of benchmarking across the organisation. There are a range of meetings where data is tabled. This includes the monthly staff, quality, health, and safety, falls, and registered nurse (clinical) meetings, however, the meeting minutes do not evidence discussion of data. There is also the triangle of support meetings four days a week, and a head of department meeting one day</p>

		<p>a week. These serve to inform managers of significant events or to review progress against specific issues. The meetings are minuted. Minutes of these meetings are made available to all staff in the staffroom.</p> <p>Resident/relative meetings are held three-monthly with these separated for family in the dementia unit, family in the psychogeriatric unit and a meeting for residents and family in the hospital and rest home units.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice. The service addresses health and safety by recording hazards and near misses, sharing of health and safety information and actively encourage staff input and feedback. There are three health and safety goals currently being progressed through the meetings. The service ensures that all new staff and any contractors are inducted to the health and safety programme with a training completed by staff as part of orientation (staff records confirmed that these had been completed). Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>There are six health and safety representatives (two from the maintenance team, the facility and clinical nurse managers, a HCA, and one clinical team leader. Two representatives have completed level one training and one has completed level two training. One health and safety representative was interviewed, and they could describe their role as per legislation and policy. Staff were able to give examples of where improvements had been made after issues had been raised.</p> <p>There have been a number of improvements in the service since the last audit. They include improvements in the how education is presented to staff to support greater attendance of staff, the introduction of an electronic human resource system, refurbishment to some internal units, and a garden upgrade. Managers and staff interviewed commented on the change in organisational culture with a more open, positive, and supportive approach provided.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	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. Incidents are included in the Radius key performance indicators (KPI) with these tabled in relevant meetings (link 1.2.3.6). A review of eighteen incident/accident forms raised in 2021 identified that all forms included review by a RN at the time of the incident. Neurological observations were not always implemented for all those reviewed where there had been an unwitnessed fall or suspected injury to the head (link 1.3.6.1).</p> <p>Discussions with the facility manager and regional manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications made since the last audit included those for pressure injuries, a shortage of registered nurses, physical aggression by a resident to another person, and wandering from a secure unit offsite. All included documentation of the event, strategies in place to manage any issues prior to the event happening, and</p>

		triggers that had potentially pre-empted the event.
<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. Eleven staff files were reviewed including the facility manager, clinical nurse manager, a clinical team leader, two RNs, four HCAs, one diversional therapist, and the maintenance manager. All files included confirmation that the recruitment process which included reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals had been followed. Health professionals had a current annual practicing certificate.</p> <p>There is an orientation programme in place with staff stating they are buddied for two weeks. HCAs stated that they were rostered onto different shifts with their buddy and to different levels of care so that they could understand the service as a whole. Staff are required to complete written core competencies during their induction. These competencies are repeated annually.</p> <p>There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. There are toolbox talks that have been provided to staff that allow for training around specific topics or to target specific staff that need that training. Of the 19 RNs on site (including the clinical nurse manager and clinical team leaders), nine have completed their interRAI training. Registered nurses are supported to maintain their professional competency. Registered nurses have access to external education sessions.</p> <p>Radius links to the CareerForce programme to ensure that staff enrol in NZQA approved training after six months of starting. There is now a CareerForce assessor on site. There are 91 HCAs employed in the service. Fourteen have achieved level 0, four have achieved level 2, eight have level 3, and 60 have level 4 training completed. There are five staff who have been employed in the service for less than six months.</p> <p>Dementia standard training is a requirement for all staff working in the secure units (dementia and psychogeriatric). There are 71 HCAs who potentially work in these units. There are 14 who have level 0, four have level two, eight have completed level 3, and 45 have completed level four training. There are also four enrolled in the level 0 training. The DT and two activity coordinators have completed level four training and two activity coordinators have completed level three (with dementia) training. Twenty-one HCAs have completed the dementia standards and 33 HCAs are in progress of completing. A corrective action plan is in place to ensure all staff working in the dementia units attains required qualifications. Five of the HCAs in the progress of completing the training have been employed in the unit for over two years and have completed their assessments.</p>
Standard 1.2.8: Service	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service

<p>Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>delivery. The clinical nurse managers and clinical team leaders are registered nurses (RNs) and share the on call with the facility manager also available.</p> <p>The service is divided into six separate units (two secure psychogeriatric units, two secure dementia units, and two hospital/rest home units). HCA turnover has been low since February 2021. There are three registered nurse vacancies with these positions being advertised. Rosters reviewed for the past three months confirmed that any person on leave is replaced with a bureau staff member.</p> <p>Staff are allocated to each unit as follows:</p> <p>McLeod (two rest home and 26 hospital residents in a 30-bed unit including two YPD, one ACC, one respite): five HCA (two long and three short shift) on a morning shift; five HCA in the afternoon (two long and three short shift); one HCA overnight.</p> <p>Reuben (one rest home and 23 hospital residents in a 27-bed unit including five residents under a palliative care contract): four HCA (three long and one short shift) on a morning shift; four HCA in the afternoon (two long and two short shift); one HCA overnight.</p> <p>There is one HCA who floats between McCleod and Reuben overnight. There is one registered nurse on each of the units each shift.</p> <p>Church (15 residents in a 15-bed dementia bed unit): two HCA (long shift) on a morning shift; two HCA in the afternoon (long shift); one HCA overnight.</p> <p>Munroe (15 residents in a 15-bed dementia bed unit): two HCA (long shift) on a morning shift; two HCA in the afternoon (long shift); one HCA overnight.</p> <p>There is one registered nurse rostered on from 8am to 4.30pm to the two units (Munroe and Church).</p> <p>Best (15 residents in a 15-bed psychogeriatric unit): three HCA (long shift) on a morning shift; three HCA in the afternoon (two long and one short shift); two HCA overnight.</p> <p>Scott (15 residents in a 15- bed psychogeriatric unit): three HCA (long shift) on a morning shift; three HCA in the afternoon (two long and one short shift); two HCA overnight.</p> <p>There is a registered nurse on each shift on each unit.</p> <p>Residents, family, and the GP stated that there were sufficient staff to meet the needs of the resident and to accommodate the layout of the facility. McLeod has one extra HCA on the morning and afternoon as seen above because the unit is long. Staff and relatives reported there was good access to a RN at all times.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	<p>FA</p>	<p>The resident electronic files sampled were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record.</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>Other residents or members of the public cannot view sensitive resident information. Resident electronic files require authorised login and password access. Paper-based files are protected from unauthorised access by being held in a locked office. Files are integrated.</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>The service has admission policies and processes in place. Referring agencies establish the appropriate level of care required prior to admission of a resident. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service, including admission into the dementia care and psychogeriatric care units. The clinical team leaders screen all potential residents prior to entry and records all admission enquires.</p> <p>The admission agreement form in use aligns with the requirements of the contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement. Residents and families interviewed verified they received information prior to admission and had the opportunity to discuss the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. Residents who require admission to hospital or transfer are managed appropriately and relevant information is communicated to the receiving health provider or service. Two staff accompany the transfer of psychogeriatric or dementia level of care residents to hospital. A computer-generated transfer form and supporting documentation accompanies residents to the receiving facility and communication with family is documented.</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>	PA Moderate	<p>There are comprehensive policies and procedures in place for all aspects of medication management. There were no residents self-administering on the day of audit. There are two medication rooms in the hospital/rest home unit, one in each wing and both have secure keypad access.</p> <p>Dementia and psychogeriatric level of care: There are medication rooms in each unit (two dementia and two psychogeriatric) in the main building. Registered nurses administer medications in the psychogeriatric units and senior level 4 HCAs administer medications in the dementia units with RN oversight. As required medications are authorised by an RN. Medications are reconciled on delivery. The medication room air temperatures were within acceptable limits. Medication fridge temperature were recorded daily. The units</p>

		<p>access the hospital level stock when required.</p> <p>Ten paper-based medication charts were reviewed (six psychogeriatric and four dementia). All charts reviewed had photo identification and allergy status documented. All medication charts evidenced three monthly reviews by the GP/psychogeriatrician. Prescribed medication is signed after being administered. All 'as required' medication prescribed had indications for use documented by the GP. Effectiveness of 'as required' medication administered was documented in the progress notes. The RNs and GP use a telephone order system which is managed according to protocol.</p> <p>Rest home and hospital level of care: There is a secure medication room in each unit (one in Rueben and one in McLeod).</p> <p>Medication fridges had daily temperatures checks recorded, the medication room in Rueben unit had several room temperature entries recorded 26 and 28 degrees Celsius. Registered nurses or senior HCAs administer medications and have completed their annual competency assessments. There is a signed agreement with the local pharmacy. The facility uses a robotics pack medication management system for the packaging of all tablets. There is documented evidence that all medications, including robotic packages received are checked and recorded. The facility does not have standing orders. Eyedrops and other liquid medications were dated on opening.</p> <p>The facility utilises a paper-based medication management system. Twelve medication profiles were reviewed (ten hospital and two rest home care). All charts reviewed had photo identification and allergy status documented. All medication sheets evidenced three monthly reviews by the GP. Prescribed medication is signed for on the medication signing sheets after being administered as witnessed on the day of the audit. All 'as required' medication prescribed had indications for use documented by the GP. Effectiveness of 'as required' medication administered was documented in the progress notes.</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>	FA	<p>All meals are prepared on-site by a contracted food service. The kitchen manager/chef is supported by two cooks and a kitchenhand (6am-2.30pm and 4pm-7pm) on duty daily. The four weekly winter and summer menu has been reviewed by a dietitian in June 2021. The menu can be changed to meet the resident preferences. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed as part of the care plan review and the kitchen is notified of any change in dietary requirements. The dietary profiles in the kitchen were reflective of the residents' current dietary needs. Pureed meals are provided and presented moulded shapes (sighted). Resident dislikes are accommodated. Lip plates are provided to encourage resident independence with eating. Meals are plated in the kitchen and transported in hot boxes to each unit kitchenette. There is an overnight store cupboard where staff can access additional foods. Adequate fluids are delivered to the kitchenette fridges including smoothies and thickened fluids. There were "finger foods", yoghurts, ice-cream, sandwiches and home-</p>

		<p>baking readily available for the dementia care and psychogeriatric residents.</p> <p>The food control expires 10 April 2022. All kitchen staff have completed food safety training. The temperatures of refrigerators, freezers, chiller, incoming chilled goods and end cooked food and meat temperatures are taken and recorded on the food service app. All food is stored appropriately, and date labelled. Cleaning schedules are maintained.</p> <p>Residents and relatives have the opportunity to feedback on the service through meetings and surveys. There was a resident/relative food survey completed in February 2021 with overall satisfaction with quality and variety. No corrective actions were required. Residents and the family members interviewed were very happy with the quality and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau and referring agency. 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. Anyone declined entry would be referred back to the referring agency for appropriate placement and advice.</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>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative (as appropriate). InterRAI assessments were completed in all long-term resident files reviewed. An initial nursing assessment and an interim care plan is completed. Personal needs, outcomes and goals of residents are identified. Resident files reviewed demonstrated that a range of assessment tools were completed in resident files and reviewed at least six monthly including (but not limited to); falls, pressure areas and continence.</p> <p>Vital signs and weights were monitored on a weekly to monthly basis dependant on needs. Behaviour assessments had been completed on admission in the two-dementia care and three psychogeriatric care resident files reviewed. Behaviour assessments had been reviewed six monthly or earlier as required for behavioural concerns. The outcomes of assessments formed the basis of the long-term care plans.</p> <p>Assessment process and the outcomes are communicated to staff at shift handovers through verbal and written shift reports, communication books, progress notes and care plans. Residents (rest home and hospital) and family interviews stated they were involved in the assessment process on admission and ongoing.</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>Eleven resident care plans were reviewed on the electronic resident management system. The respite care resident (hospital) and palliative care resident in GP bed were not required to have long-term care plans. The one respite resident file reviewed included assessments and a short stay care plan. Long-term care plans reviewed recorded the resident's problem/need and objectives/interventions to support resident needs and goals, all long-term care plans had documented interventions that reflected the residents' current needs and goals. A care plan summary for each resident provides a guide for HCAs to follow. Staff interviewed reported they found the plans easy to follow.</p> <p>Behaviour management plans in the files of the dementia and psychogeriatric residents reflected the outcomes of the behaviour assessments. Care plans identified the involvement of allied health professionals including physiotherapist, dietitian, mental health services for the older person and psychogeriatrician.</p> <p>Residents (as appropriate) and their family/whānau confirmed they were involved in the care planning process as evidenced in the family contact form. Short-term care plans reviewed were in use for changes in health status. Short-term care plans were reviewed and resolved or added to the long-term care plan if an ongoing problem.</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 Moderate</p>	<p>Clinical team leaders, registered nurses (RNs), and healthcare assistants follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the wound care nurse specialist or the mental health team). If external medical advice is required, this will be actioned by the GP. The GP had not been notified of three residents with weight loss.</p> <p>The mental health services for the older person team have been involved in assisting the RNs with behaviour assessments and appropriate placement of residents within the two psychogeriatric units. One unit is identified as a quieter unit than the other. The interventions and reviews for behaviours are clearly documented within care plans, however hourly checks for two dementia care residents had not been completed.</p> <p>Sufficient continence products are available and resident files reviewed included a continence assessment and plan as part of the plan of care. Specialist continence advice is available through the DHB as needed and this could be described.</p> <p>Staff have access to sufficient medical supplies (e.g., dressings). Wound assessment, wound management and evaluation forms were in place for 23 wounds (seven hospital residents, seven rest home, five dementia care residents and four psychogeriatric residents). There was one psychogeriatric resident with a</p>

		<p>facility acquired stage 3 pressure injury of sacrum and one rest home resident with a facility acquired unstageable pressure injury on the heel. The DHB wound nurse specialist has been involved in wound care for the residents.</p> <p>Wound management, monitoring, photos, and short-term care plans were in place for wounds which had been reviewed as per the planned frequency. However wound assessment and management documents did not always document progression towards wound healing.</p> <p>All have appropriate care documented and provided, including pressure relieving equipment. Access to specialist advice and support is available as needed.</p> <p>The RNs interviewed confirmed there is adequate pressure relieving equipment available and in use including alternating air mattresses, pressure relieving cushions and bootees.</p> <p>Interviews with HCAs demonstrated understanding of the individualised needs of residents. Monitoring forms reviewed included repositioning charts, monthly weight and vital sign monitoring, pain monitoring, food and fluid charts, behaviour charts, blood sugar monitoring and daily activity checklists. Neurological observations had not been completed for all unwitnessed falls as per protocol and a behaviour charts for one resident (hospital) were commenced but not fully completed as required.</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>	CI	<p>A qualified diversional therapist (DT) leads the activities team, which includes three activities coordinators (one is progressing through the DT course, one has dementia unit standards, and one is newly employed). The DT and activity coordinators work Monday to Friday from 9.30 am-4 pm Monday to Friday. Two activities coordinators cover the hospital section, one in McLeod wing and the other in Reuben wing. The DT and one activity coordinator implement activities in two units each (one dementia and one psychogeriatric). The HCAs coordinate/implement activities in the weekends as set on the programme, either group or individual one on one time. There are activity trolleys and resources readily available for staff, residents and families to use. In the secure units each resident has a folder that contains a hard copy of the leisure plan, about me and life history to assist staff (including bureau staff) to initiate discussion or individual activities with the resident. Each unit has their own activity programme which includes group activities and one-on-one time. Each unit programme has a guide of indoor activities, outdoor activities and quiet time activities.</p> <p>On the day of audit, residents in all areas were observed being actively involved with a variety of activities either in a group with the activity coordinator or one-on-one time with HCAs such as reading, puzzles, crafts and board games. The activities programme is designed for high-end and low-end cognitive functions and meets individual cognitive, intellectual, emotional, sensory and physical needs. Activities include (but are not limited to) arts, crafts, music, baking, exercise, board games, walking groups, bowling challenge, pampering sessions, floor games, newspaper reading, table activities, gardening, flower arranging, movies,</p>

		<p>music, reminiscing, sing-a-longs, colouring art and happy hours. The programme for dementia and psychogeriatric residents also includes individual time and household activities.</p> <p>There are integrated activities held in the large communal recreation room (with kitchenette) and access to an outdoor courtyard. Integrated activities include church services, weekly entertainment, KYF keep on your feet) exercise programme, mobile library, bowling challenge, ladies' group and men's group activities. Each unit has a cooking group. The canine friends visit all areas. Festive occasions and themed events are held with staff involvement. There are weekly van outings for residents of all levels of care and include picnics/scenic drives to places of interest such as beaches and mystery tours. There are two staff on outings, including the van driver who has a first aid certificate.</p> <p>Over the last 18 months the service has been focused on increasing community connections and integrated activities for all residents. The success of this goal is demonstrated in the 2020 resident/relative survey.</p> <p>All residents have an activity assessment completed on admission and have an individual leisure plan and social activity chart on the electronic resident management system. Leisure plans are evaluated six-monthly as part of the MDT case conference with the RN, DT/activity coordinator and resident/relative. Younger people have an individual leisure plan that includes their interests, hobbies and community connections. They are supported to attend community events. The activity coordinator makes daily contact and identifies any activities on the programme they would like to attend and ensure their recreational needs are being met.</p> <p>Family members are invited to the two monthly unit meetings where residents (as appropriate) and family members can provide feedback on the programme. A resident advocate attends meeting six-monthly. Residents and relatives interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate initial care plans within three weeks of admission. The long-term care plan has been evaluated six-monthly for all long-term residents with the exception of two psychogeriatric residents. Case conference checklists are signed by those present including the GP at the three-monthly review. The family contact forms reviewed across all units reflect that family are invited to attend multidisciplinary team (MDT) reviews and informed on GP reviews. The care plan evaluations that have been completed, document if the resident goals have been met or unmet.</p> <p>Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files reviewed. Where progress is different from expected, the service responds by initiating changes to the care plan. The family contact forms reviewed in the rest home/hospital wings reflect that family are invited to attend multidisciplinary reviews and informed on GP reviews.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referral through the clinical team leaders and specialist referrals are made through the GP.</p> <p>Discussion with the RNs who work in the dementia and psychogeriatric units identified that the service has access to a wide range of support either through the GP, DHB specialists, mental health services for the older person, assessment teams and contracted allied health services. A staff member or family member will accompany residents on transfer to hospital. All transfer documentation is forwarded in the yellow hospital transfer envelope.</p> <p>There was evidence of where a resident's condition had changed, and the resident was reassessed for a higher or different level of care from rest home to hospital level of care. Discussion with the clinical team leaders identified that the service has access to a wide range of support either through the GP, DHB specialists and contracted allied services.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Sharp's containers are available and meet the hazardous substances regulations for containers. Chemicals sighted were clearly labelled with manufacturer's labels and stored safely throughout the facility. Safety datasheets were available. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. A hazard register was evident that identified hazardous substances. Staff interviewed indicated a clear understanding of processes and protocols.</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>	FA	<p>The building has a current building warrant of fitness that expires on 22 November 2021. The facility is in two buildings, one hospital which has three wings and a dementia/psychogeriatric section comprising of four 15-bed wings.</p> <p>The building has a number of alcoves, lounge, and dining areas in each wing. There is a full-time maintenance manager and a part-time maintenance person employed to address the reactive and planned maintenance programme. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. All ensembles, showers and utility areas had non-slip vinyl flooring. The facility has sufficient space for residents to mobilise using mobility aids and residents were observed moving around freely. The</p>

		<p>external area is well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>Medical and electrical equipment including hoists and electric beds, oxygen concentrators, weighing scales and syringe drivers were recently serviced. Medical and electrical testing of equipment is carried out by an approved contractor as per the planned maintenance programme.</p> <p>A random call bell check is completed monthly to cover all wings within Radius Althorp. There is a six-monthly internal audit process for building and environmental check and the Care and Hygiene Needs audit with no corrective actions required in the last audit</p> <p>Each secure unit has a dining room and satellite kitchen. There is a separate lounge area with seating placed to allow for individual and small group activities and a family room for quieter activities or visitors. One dementia unit has a larger activity room with access to the outdoor courtyard. Each unit has several exit/entry doors out into the courtyard with seating, shade, raised gardens and walking pathway.</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>All rooms in the hospital/rest home facility have full ensuites large enough to cater for hospital level residents and the associated equipment and staff. There are communal toilets near each lounge. There is a mix of shared ensuites and communal toilet/showering facilities in the dementia unit and psychogeriatric units. Communal toilets are clearly labelled and have privacy systems in place. Fixtures, fittings and toilets/showers are constructed for ease of cleaning. Residents (as appropriate) interviewed, confirmed their privacy is assured when staff are undertaking personal cares. There are flowing soap and hand sanitizer available in the ensuites.</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 residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids, including those required by hospital level care residents. Resident bedroom doors in the dementia unit and psychogeriatric unit have meaningful photos on doors to assist residents to find their rooms. Residents are encouraged to personalise their bedrooms as viewed on the day of the audit.</p>
Standard 1.4.5: Communal	FA	<p>Rest home and hospital: The communal areas include the open plan main lounge/dining area (with a</p>

<p>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>		<p>kitchenette in the hospital wings) and several smaller lounges and family rooms in each wing. The lounge/dining areas are large enough to cater for activities. Seating and space can be arranged to allow both individual and group activities to occur as observed on the days of the audit. The communal areas are easily and safely accessible for residents and visitors who would prefer a quieter activity or space.</p> <p>Dementia and psychogeriatric units: Each unit is spacious with a central observation area and seating and activity tables. There is a kitchenette and dining area with separate lounge and family room for visitors or quieter activities. Each unit has an activity resource area which is readily available to residents. There is a large recreational room in the main corridor that is used for combined activities, entertainment and church services. There is a kitchenette used for morning and afternoon teas, baking activities and there is access to a safe outdoor area.</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 in which the service is being provided.</p>	FA	<p>The facility has a dedicated team of cleaning staff who have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Cleaning trolleys are stored in a locked room when not in use. Safety data sheets were available. Residents and family members interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is undertaken on-site by dedicated laundry staff. The laundry is spacious and well organised and divided into a 'dirty and clean' area. Laundry staff member interviewed described appropriate systems for managing infectious laundry. Safety data sheets were sighted in the laundry. All chemicals were stored in a locked cupboard. Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an emergency health management plan in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Radius Althorp has an approved fire evacuation plan dated 24 October 2013. Fire evacuation drills occur six-monthly with the last evacuation drill occurring on 13 May 2021. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (BBQ). The service has a backup system for emergency lighting and battery backup.</p> <p>Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are available. There are civil defence kits in the facility that are checked six-monthly. There is sufficient water (water tanks) stored to ensure for twenty litres per day for seven days per resident. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit. The service has a visitors' book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and all resident rooms are appropriately heated and ventilated. Documentation and visual inspection evidence that the environment is maintained at a safe and comfortable temperature. The residents and family interviewed confirmed temperatures were comfortable. All rooms have external windows that open, allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Radius Althorp has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. An experienced registered nurse has been newly appointed in May 2021 as the designated infection control (IC) nurse with support from the clinical nurse manager. The infection control nurse has a signed job description. Minutes of the monthly infection control meeting are available for staff. The Radius infection control programme is linked into the quality management system and reviewed annually in April.</p> <p>Influenza vaccines are offered to residents and staff annually. Residents and staff have received Covid vaccines. Visitors and family are advised not to visit if they are unwell. Covid screening on entry to the service has continued. There are adequate hand sanitizers available.</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 IC nurse has completed a MOH on-line course and is registered to attend an infection prevention and control study day at the DHB in September 2021. The IC nurse is supported by an infection control committee who are representative of the clinical, cleaning, food, laundry, and maintenance and meet monthly. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse has good support from expertise within the organisation with a regional manager who has the infection prevention and control portfolio. There is external advice from the DHB infection control specialist, GP, the local laboratory, and public health.</p> <p>There is sufficient personal protective equipment available with each unit having their own supply.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and</p>	FA	<p>There are Radius Althorp infection control policies and procedures appropriate for the size and complexity of the service. The infection control policies were reviewed April 2021 in consultation with Radius infection control nurses. There is a Radius Covid table-top plan and resource folder with information from the DHB</p>

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.		and HealthCERT.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Staff receive infection control education on orientation including handwashing, standard precautions, and correct use of personal protective equipment. There has been additional education provided around Covid alert levels, restrictions and donning and doffing of personal protective equipment. Staff complete handwashing competencies. Staff are updated on infection control matters through the e-case message board, shift handovers and regular staff meetings.</p> <p>Visitors are advised of any outbreaks of infection and are advised not to visit until the outbreak has been resolved. Information was provided regularly to residents and visitors regarding Covid alert levels and visiting restrictions by phone or email.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the Radius Althorp infection control manual. Individual resident infection reports are completed for all infections which includes signs and symptoms of infection, treatment, follow-up, review, and resolution. Short-term care plans are used for residents diagnosed with infections as evidenced in the resident files reviewed. Infection events are entered into the monthly electronic data base. The IC nurse collates the data and completes an end of month analysis for trending and any areas for improvement. Information is provided to the infection control committee and clinical/quality meetings. This data is monitored and evaluated monthly, and benchmarking occurs against other Radius facilities occurs.</p> <p>There have been no outbreaks since the last audit.</p>
Standard 2.1.1: Restraint minimisation	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. The restraint coordinator is the clinical nurse manager for the dementia and psychogeriatric units. There are

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>policies and procedures in place that align with the restraint minimisation and safe practice standards and include the definition for enablers and restraints. The use of restraint is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked. There were no restraints on the day of audit and three hospital level residents using enablers (bedrails). There was documented evidence of voluntary use of enablers. Use of enablers is reviewed three-monthly. Staff receive training and education around restraint, enablers, and challenging behaviours at orientation and ongoing as part of the training plan.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	There are a range of meetings where data is tabled. This includes the monthly staff, quality, health, and safety, falls, and registered nurse (clinical) meetings, however, the meeting minutes do not evidence discussion of data. There are also infection control and restraint meetings that do include evidence of discussion of data. Staff interviewed stated that they do discuss data and look for opportunities for improvement.	The staff, quality, health and safety, falls, and registered nurse (clinical) meetings minutes do not include evidence of discussion of data with opportunities for improvement	Document evidence of discussion of data in the relevant meeting minutes and show evidence of improvement as a result of the discussions.

			identified.	180 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>Medication administration practice complied with the medication management policy for the medication rounds sighted. Controlled medications are checked and recorded on arrival from the pharmacy. There are two signature entries on the medication charts when administering controlled medication. The entries in the controlled drug register had not been signed as required.</p>	<p>a) One medication room had out of acceptable range temperatures recorded with no corrective actions.</p> <p>b) Seven medication entries in the controlled drug register for the hospital / rest home unit do not have a second signature recorded against the entry.</p>	<p>a) Ensure corrective actions are completed when medication room temperatures are outside of acceptable range.</p> <p>b) Ensure entries in medication registers complies with legislation, guidelines, and protocols.</p> <p>30 days</p>
<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</p>	<p>PA</p> <p>Moderate</p>	<p>Radius has an updated manual for clinical policies and procedures, this include timeframes for neurological observations to be completed after unwitnessed falls. The care plans document appropriate interventions and include required monitoring and the frequency where necessary. Eight incident and accident forms where unwitnessed falls occurred were reviewed. Neurological observations were commenced but not completed (for five of eight) as per protocol.</p> <p>Wound assessments and management plans are in place for all wounds reviewed. Wound monitoring occurs on the electronic system, but the wound</p>	<p>The following shortfalls were identified:</p> <p>a) Neurological observations had not been completed for five of eight unwitnessed</p>	<p>Ensure monitoring forms are completed as required.</p> <p>90 days</p>

desired outcomes.		<p>bed, exudate and surrounding skin descriptions have not been completed to show progression towards healing.</p> <p>Monitoring charts are utilised to monitor a resident's progress where there is a change to health status, however not all monitoring forms had been completed as required.</p> <p>The RNs are required to state the frequency of monitoring and HCAs or RNs complete the form. The electronic system has fifty-two codes allocated to reflect different interventions when monitoring challenging behaviour; for example the code 1 A reflects 1:1 intervention with a resident. Staff choose the correct code to reflect the correct intervention for each episode of behaviour. The two residents in the dementia unit and three residents in the psychogeriatric unit had behaviour charts completed as required. However, one hospital level resident monitoring form was completed using the 1A code repetitively; this code is not reflective of the appropriate intervention that is helpful to de-escalate the behaviour for this particular resident. For the same resident, triggers for the behaviour were also not completed.</p>	<p>falls as per protocol.</p> <p>b) Five wound assessment (two hospital and three rest home) and management plans do not reflect progression towards healing (wound bed, exudate level, surrounding skin.</p> <p>c) Interventions and triggers for one hospital resident with challenging behaviour is not recorded: and</p> <p>d) Two dementia level of care residents (one at risk of absconding and one with high falls risk) did not have hourly resident checks in place as documented in the care plan.</p>	
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The activity team set a goal to create a community of people living full lives within the limitations of the ageing process. Increasing community connections and involvement in integrated activities within and outside of the facility has been achieved for residents at all</p>	<p>The activity team encourage residents at all levels of care (as appropriate) to join in integrated activities and events within and outside of the facility. Places of interest to visit link to residents' previous occupations such as the annual visit to the fire station. Dementia level of care residents visit the Bayfair shopping mall monthly. The ladies group visit the RSA and enjoy being there for the band practices. The men's group visit places of interest including the Waihi pub. Residents of all levels attend opportunity live entertainment. The bowling challenge includes residents from all units. The residents are involved in fundraising for community charities such as breast cancer, food bank and women's refuge. The village knitter-knatter group engage with the residents in fundraising events. Presently the ladies' group are making hand-painted bandanas for Daffodil Day. During lockdown one 99-year-old hospital level resident was sponsored for walks and money raised went to Cancer Awareness Society. Every February there is a Radius Althorp "Big Day Out" which was at Ferguson Park in 2020 and at McLaren Falls in 2021. There is a combined effort from all management, staff and families to ensure all resident needs are met including appropriate transport to and from the venue for those in wheelchairs, dietary requirements are met, behaviours of concern are known, and action/alternative plans are in place, falls risk managed, seating was adequate, and toilets were accessible. Photos evidenced residents enjoying the McLaren Falls big Day Out with picnics, barbeque, walks and games and feeding the ducks. There were safety barriers along the walkways and the staff ensured the parking area was</p>

		levels of care, particularly for dementia and psychogeriatric residents. This is demonstrated in increased resident/relative satisfaction rate in the last survey.	safely cordoned off. There was constant supervision of dementia care and psychogeriatric residents and regular roll calls. There were 32 residents from the secure units who attended (11 psychogeriatric and 21 dementia care). The 2020 resident/relative satisfaction survey for activities was 94% very satisfied/satisfied/quite satisfied compared to 70% for 2019 activity survey.
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End of the report.