# Radius Residential Care Limited - Radius Thornleigh Park

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Radius Residential Care Limited

**Premises audited:** Radius Thornleigh Park

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

**Dates of audit:** Start date: 30 September 2021 End date: 1 October 2021

**Proposed changes to current services (if any):** The service has a contract for younger person disabled with five residents under this funding at the time of audit, however the current certification does not include residential disability-physical level care. This audit verified the service as suitable to provide this level of care with an application sent to HealthCERT at the time of audit.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 48

# 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 |
|  | 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

Thornleigh Park is part of the Radius Residential Care Group. The service provides hospital (medical and geriatric) and rest home level care for up to 63 residents. At the time of the audit there were 48 residents.

This certification audit was conducted against the Health and Disability Service Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff. As part of this audit the service was verified as suitable to provide residential disability – physical level care.

The service is managed by a facility manager who has been in the role since May 2021 and is an experience manager and non-practicing registered nurse. The facility manager is supported by an experienced clinical nurse manager. Residents and family members interviewed spoke positively of the services provided at Thornleigh Park.

This certification audit identified no areas for improvement.

## 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. |

The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review process. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents’ rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

## 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. |

A facility manager and clinical nurse manager are responsible for the day-to-day operations. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities, including Radius key performance indicators, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents’ meetings are held bi-monthly, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. 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 roster that provides sufficient and appropriate coverage for the effective delivery of care. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

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

There is welcome pack for potential residents and family members. The registered nurses’ complete assessments including interRAI, care plans and evaluations using an electronic system. Residents/relatives are involved in planning and evaluating care. Service delivery plans demonstrate service integration and allied health professionals involved in the care of residents. Care plans are evaluated six monthly or more frequently when clinically indicated. The general practitioner reviews the residents at least three-monthly.

The activity coordinator provides an activities programme that meets the physical and cognitive abilities of the rest home and hospital residents and younger persons. The programme includes outings, volunteers and community visitors. Each resident has an individualised plan.

The medication management system follows recognised standards and guidelines for safe medicine management practice. Staff complete competency assessments for the administration of medications. The general practitioner/nurse practitioner reviews medication charts at least three-monthly.

Meals are prepared on site. A dietitian has reviewed the menu. Individual and special dietary needs are catered for. Residents interviewed responded favourably regarding the food that was provided.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The building holds a current warrant of fitness. There is a reactive and planned maintenance system in place. Chemicals are stored safely throughout the facility. There is a mix of ensuite and communal toilets/showers. Resident bedrooms are spacious and personalised. Internal communal lounges and dining rooms are easily accessible. External areas are safe and well maintained with shade and seating available. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services. There is a qualified first aider on each shift.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. At the time of the audit there were no residents using restraints and one resident using enablers. Staff receive regular education and training on restraint minimisation and managing challenging behaviours.

## Infection prevention and control

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| --- | --- | --- |
| 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. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Radius facilities. Staff receive ongoing training in infection control.

## 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 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The Code is available in both Māori and English versions and the pamphlets and booklets are readily accessible  Discussions with staff, including: five healthcare assistants (HCA), three registered nurses (RN) and one recreation therapist confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Three housekeepers, one laundry person and one chef were also able to describe resident rights. Ten residents (two rest home, including a younger person and eight hospital) and two hospital relatives were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice. Staff receive training on the Code, last occurring in June and August 2021. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Seven resident files were reviewed, (four rest home including one resident under long-term chronic health condition – LTS-CHC and three hospital level including one younger person with a physical disability). Informed consent processes had been discussed with residents (as appropriate) and families on admission. Written general consents and specific consents (e.g., influenza vaccine and Covid vaccine consents) were sighted on the electronic files. Permissions granted were included in the admission agreement. Advance care plans where available were sighted on the electronic resident files. The registered nurses and healthcare assistants confirmed verbal consent is obtained when delivering care.  Resuscitation status was signed by the residents and verified by the general practitioner or nurse practitioner. 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. Copies of the EPOA (enduring power of attorney) where available or activated were held in the resident file. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents’ family/whānau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, (e.g., attending cafes, and restaurants). Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process and all complaints are recorded on the electronic system. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility. Complaints are reported to staff via the various meetings and documents comprehensive feedback. There have been 23 complaints made in 2021 year to date. The complaints reviewed included follow-up meetings, letters and resolutions. Complaints have been collated and reviewed quarterly. The quarterly report includes follow up and action plans following complaints. There have been 11 care related complaints. Staff training and daily staff huddles have worked to address issues raised. Residents interviewed had no complaints regarding care at the time of audit. Additional training has included complaints management (September 2021), communication (June and September 2021) as well as tool box talks such as falls and admission processes. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code are included in the resident information pack that is provided to new residents and their family. The facility manager and registered nurses discuss aspects of the Code with residents and their family on admission. The management team provide an open-door policy, and this is reflected in interview by residents and relatives. Resident meetings in each household also allows for discussions on rights. Advocacy services information is provided with the complaint’s procedure and complaint forms. Advocacy information is displayed at reception. Residents and relatives interviewed identified they are well informed about the Code of Rights. Monthly resident/relative meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident’s privacy and dignity. Contact details of spiritual/religious advisors are available. Staff education and training on abuse and neglect has been provided, last occurring in April and August 2021 with high staff attendance. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Thornleigh Park 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. Tui Ora whanau health and wellbeing services are available for advice and to liaise with Māori residents as needed. At the time of audit, there were two residents who identified as Māori. One resident file was reviewed and included a Māori health plan. The resident was very happy with their care and support, including cultural care. Family/whānau involvement is encouraged and documented well in assessment and care planning and visiting is encouraged. A Māori reverend visits on a regular basis. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values. The 2021 satisfaction survey identified 71% satisfaction outcome for cultural/spiritual needs being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities and staff sign a copy on employment. The staff/quality meetings have occurred at least monthly since the new manager commenced (May 2021) prior to June they were one to two-monthly . All meetings include discussions on professional boundaries as needed and concerns as they arise. Management provides guidelines and mentoring for specific situations. Interviews with the facility manager, clinical nurse manager and RNs confirmed an awareness of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The Radius quality programme is designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. Policies and procedures have been reviewed and updated at organisational level and are available to staff. Residents and relatives interviewed spoke positively about the care and support provided. Staff had a sound understanding of principles of aged care as well as support needs for younger people and stated that they feel supported by the facility manager, clinical nurse manager and nursing staff. There are implemented competencies for HCAs and RNs. There are clear ethical and professional standards and boundaries within job descriptions.  Thornleigh Park has strong community links and residents enjoy being part of the wider community including going into Taranaki hospital doing acts of kindness for the patients and staff. The service participates in local community events such daffodil day and Relay for life, Nexan walk series and Taranaki bowls and also hosts visitors at Christmas show casing Christmas lights.  The introduction of eCase as a management information tool in 2018 has improved management ability to monitor the work practices of the staff and to respond to residents or families concerns with full knowledge of the service being carried out. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | During Covid lockdown the manager communicated through email updates, newsletters and zoom calls from the facility, to ensure family and friends of the facility felt connected and informed with the covid related information, residents wellbeing, activities, highlights of their day etc to ensure they did not worry about their residents/loved ones, while they could not visit. The resident/families’ meetings documented monthly and encourage feedback from for residents and families, the meetings are also a forum for guest speakers.  Residents and family members interviewed confirmed they were welcomed on entry and were given time and explanation about services and procedures. Family members also stated they are informed of changes in the health status of residents and fifteen incidents/accidents sampled confirmed this. The facility manager and clinical nurse manager have an open-door policy. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Thornleigh Park is part of the Radius Residential Care Group. The service is certified for rest home and hospital; level care (medical and geriatric). The service has a contract for younger person disabled with five residents under this funding at the time of audit. This audit verified the service as suitable to provide this level of care with an application sent to HealthCERT at the time of audit.  The service cares for up to 63 residents requiring hospital (geriatric and medical services) and rest home level care. There are 49 dual-purpose beds and 14 rest home only. On the day of the audit, there were 48 residents in total, including 32 residents receiving rest home level care. There were 16 residents receiving hospital level care. There were two long term chronic condition funded residents( both rest home), and five residents funded through the younger person disabled contract (one hospital level and four rest home level).  Thornleigh Park has a documented business plan 2021 – 2022 that is linked to the Radius Residential Care group strategies and business plan targets. The mission statement is included in information given to new residents. An organisational chart is in place. Annual goals have been identified and strategies are documented to meet their goals around building community relationships, staff retention, staff training and a change management plan that includes embedding Radius Policies and procedures.  Quarterly reviews are undertaken to report on achievements towards meeting business goals and action plans from previous external audits. The facility manager reports monthly to the regional manager on a range of operational matters in relation to Thornleigh Park, including strategic and operational issues, incidents and accidents, complaints, health and safety.  The facility manager is a non-practicing registered nurse) who is experienced in aged care and has been in the role since May 2021. She has long experience in managing elderly care. A clinical nurse manager who has been in the position since October 2020 supports her. An operations manager supports the facility manager in the management role and was present during the audit.  The facility manager has completed in excess of eight hours of professional development in the past 12 months. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the facility manager, the clinical nurse manager is in charge, with support from the operations manager and registered nurses. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is an organisational business plan that includes quality goals and risk management plans for Thornleigh Park. The facility manager advised that she is responsible for providing oversight of the quality programme. Thornleigh Park is implementing the Radius quality and risk programme. Prior to May when the facility manager commenced, meetings were not always held as per schedule. Since May / June all meeting have been constantly held. Monthly staff and quality meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include detailed trend analysis and graphs. Other meetings include monthly RN and infection control meetings, quarterly health and safety meetings, monthly resident meetings and weekly head of department meetings. Meeting minutes are comprehensive and are reflective of the quality process and plan. Issues are identified, and plans are carried through from meeting to meeting until resolution. Resident/relative meetings are monthly.  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 quality monitoring programme is designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility and across the organisation. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions are evaluated and signed off when completed. Restraint and enabler use is reviewed at the monthly staff/quality meeting.  Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The overall service result for the resident/relative satisfaction survey completed in September 2021 and reflected and overall, 50% satisfaction. A corrective action plan was developed and completed and documented comprehensive follow up. The health and safety representative interviewed confirmed their understanding of health and safety processes. Three staff members has completed external health and safety stage one training. Risk management, hazard control and emergency policies and procedures are in place. Hazard identification forms and an up-to-date hazard register (last reviewed 21 July 2021) are in place. Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions.  There is an up-to-date business continuity plan dated June 2012 and a mutual operations procedure with another Radius facility This procedures documents how each facility might help the other in times of emergency. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Incidents are included in the Radius key performance indicators (KPI). There is a discussion of incidents/accidents at the monthly staff/quality meetings including actions to minimise recurrence. A review of fifteen incident/accident forms logged onto the electronic system identified that forms are fully completed and include follow-up by a RN. Neurological observations were completed for six reviewed unwitnessed falls or suspected injury to the head.  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. Essential notifications have included: two for absconding residents, three for lack of RNs, a trespass order for a family member, and one resident passed away due to natural causes; however, this became a coroner’s investigation involving police due to the resident being under the mental health act at the time of her passing. There have been two out breaks; Gastro outbreak July 2020 and respiratory outbreak August.2021. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Eight staff files were reviewed which included two RNs, and six HCAs. All staff files reviewed evidenced implementation of the recruitment process, employment contracts, completed orientation, updated job descriptions, training, and competencies.  The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Interviews and documentation reviewed confirmed that all new staff have been orientated to the new facility. New staff complete an orientation day, competencies are buddied for a period of time.  A register of RN staff and other health practitioner practising certificates is maintained. Registered nurses are supported to maintain their professional competency.  Staff are required to complete written core competencies during their induction. These competencies are repeated annually. There is an implemented annual education and training plan that exceeds eight hours annually. The training plan includes topic related to younger people such as sexuality, advocacy and communication. Staff interviewed stated that the care of younger people is included as part of the compulsory education topics. There is an attendance register for each training session and an individual staff member record of training. Five of five RNs (including the clinical nurse manager) are interRAI trained.  Careerforce is supported by the service with two level four HCAs, nine level three and five level two. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is policy in place to determine staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. There is a full-time facility manager and clinical nurse manager who work from Monday to Friday and are available on call 24/7. The service is in the process of employing an additional RN, as the time of audit the clinical nurse manager or a regular agency nurse were filling roster gaps (there were four RNs and the clinical manager at the time of audit). RNs interviewed stated that there is always an RN on duty each shift.  At the time of the audit, there were 48 residents in total, 32 rest home residents and 16 hospital residents. There is one RN on duty in the morning shift, afternoon shift and the night shift.  The RNs are supported by five HCAs on the morning shift (three long and two short shifts) and four HCAs on the afternoon shift (three long and one short shift) and two HCAs on the night shift. Additional staff are often rostered for higher acuity residents and/or days when the workload is higher, and this was seen on the roster. Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the clinical nurse manager and facility manager who respond quickly to after-hour calls. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files 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. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office and on the secure electronic system. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an enquiry information pack available for potential residents/families and an admission pack with detailed information on the services provided. The service requires approval for level of care prior to admission.  The admission agreements were signed and met the requirements of the ARCC (aged care residential contract). Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB and the relatives. The service ensures appropriate transfer of information occurs. Relatives interviewed stated they are kept well informed and involved in any referrals for treatment options. Residents in hospital or on social leave are identified and monitored through the eCase resident database. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies and procedures in place for all aspects of medication management, including self-administration. Medications were stored safely in the main medication. Registered nurses and medication competent HCAs administer medications and have completed annual medication competency (including insulin and oxygen therapy) and education. The RNs have syringe driver competency. Regular and as required medications are dispensed in blister packs. The night shift RN on duty completes a documented medication reconciliation for medications delivered. There were no self-medicating residents. The medication fridge and medication room air temperature are monitored and recorded daily and both temperatures within the acceptable temperature range. Eye drops, eye ointments and creams were dated on opening. All medications were within the expiry dates. There was no hospital stock and no standing orders. The emergency trolley and oxygen and suction were checked weekly by an RN.  Fourteen medication charts (paper-based) were reviewed (six hospital, eight rest home) and met prescribing requirements. The allergy status and photo identification were on all medication charts. ‘As required’ medications had prescribed indications for use. The effectiveness of as required medications was documented in progress notes. Mediation administration was observed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals are prepared and cooked on-site. The chef (interviewed) works 8 am to 4.30 pm. Currently an agency cook is relieving on her days off. They are supported by morning and afternoon kitchenhands. All kitchen staff are employed by Radius and have completed food safety training. The four weekly winter menus have been reviewed by a dietitian April 2021. The cook receives dietary information for all new residents and notified of any resident dietary requirements or weight loss. Resident dislikes and food allergies are accommodated. Special diets include gluten free, diary free and pureed meals. The kitchen is adjacent to the dining room and meals are served directly to the residents in the dining room. Meals are plated and delivered in hot boxes to residents in rooms and the smaller dining room kitchenette.  There is current food control plan that expires 20 January 2022. All food is stored safely, dated and labelled. The service uses an electronic tablet to record daily fridge, freezer, end cooked foods, inward goods and cleaning schedule. Internal audits are implemented to monitor performance.  Residents and family members interviewed were happy with the meals and home baking provided. Residents and relatives have the opportunity to feedback through resident meetings and surveys. The cook has direct contact with residents and receives feedback directly and from resident meetings. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Information received from hospital discharge, GP medical notes and allied health input is used to develop the initial interim care plan within 24 hours. Appropriate assessment tools have been completed on the eCase and reviewed at least six monthly or when there was a change to a resident’s health condition. Electronic care plans are developed on the outcomes of these assessments. An activity assessment is also completed for all new residents. InterRAI assessments had been completed for new residents within 21 days and are utilised as part of the six-monthly evaluation of care plans. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Long-term care plans reviewed on eCase described the support required to meet the residents’ goals as identified by the ongoing assessment process. The long-term care plans reflected the outcomes of risk assessment and interRAI assessments. There were care plans developed for specific medical conditions such as diabetes and epilepsy, risk plans, falls prevention plans, nutritional plans, pain management and behaviour management plans for residents with low cognition/mood. Residents and their family/whānau confirm they are involved in the care planning and review process. The electronic progress notes evidence resident/relative involvement in care planning and reviews.  Allied health involvement was linked to the long-term care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident’s condition changes the RN initiates a NP or GP consultation. Registered nurses interviewed stated that they notify family members about any changes in their relative’s health status including accidents/incidents, infections, GP visits, appointments, medication changes and transfers to hospital. Family interviewed confirmed this. Care plans had been updated as residents’ needs changed. Short-term care plans were in place for changes to care/health status and were reviewed regularly.  Staff have access to sufficient medical supplies including dressings. Wound assessments, dressing plans, photos and evaluations were completed on the electronic system for 10 residents including skin conditions, chronic venous ulcers, skin tears, lesions and pressure injuries. Short-term care plans were in place for all wounds reviewed. There was one palliative resident with two facility acquired pressure injuries – one stage 1 and one stage 3. There was sufficient pressure relieving devices available including air alternating mattresses, foam booties and cushions. Monitoring charts evidence repositioning as instructed on the work logs for residents at risk of pressure injury. The wound nurse specialist had been involved in the wound care of pressure injuries and chronic wounds. The ulcer clinic at DHB had been involved in the management of venous ulcers.  Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.  Electronic monitoring forms are completed and reviewed by the RN for progress against short term needs and supports. Monitoring charts include bowel charts, blood pressure, weight charts, blood sugar levels, food and fluid charts, re-positioning charts, behaviour charts, pain monitoring. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There is one activity coordinator from 9.30 to 3.30 pm Monday to Friday. She has been in the role since February 21 and has a background in early childhood education. There are networking systems in place with other diversional therapists from another local Radius rest home and other regional rest homes. Weekend activities set are coordinated by the HCAs. There are plenty of resources including the facility library. Activities take place in the recreational lounge and there is main lounge, family lounge and many small seating alcoves.  There is an integrated rest home/hospital activity programme. The weekly programme is displayed in communal areas and in resident rooms. Residents have the choice of a variety of activities, in which to participate and every effort is made to ensure activities are meaningful and tailored to residents’ needs. These include (but not limited to); daily falls prevention exercises, walks, floor games, bowls, brain games (quizzes, board games), music, news and views, movies, happy hours, sing-a-longs, arts and crafts, gardening and pampering sessions. There are room visits for those residents who choose not to participate in group activities. The ladies group enjoy high teas and afternoon teas. The men’s group enjoy outings to places of interest such as the men’s shed and barbeques. The service has a beehive in the grounds and a beekeeper maintains this for the residents. Every second month residents do RAKS (random acts of kindness) contributing to the community and fundraising for various charities.  Community visitors include entertainers and church visits. The facility is pet friendly with one resident with a dog and staff regularly visit with their pets. The service has a wheelchair hoist van. There are scenic drives, picnics, and outings to places of interest. The activity coordinator has a current first aid certificate. There has been disruption to communal activities due to Covid restrictions.  Younger persons at Thornleigh Park are supported to attend community events, community groups, shopping and socialization with family and friends. There are weekly cooking groups, weekly pamper group and knitting group. They may choose to attend activities on the programme. Many are independent and attend activities outside of the facility. Radius operate their own radio sessions with resident involvement.  Special events like birthdays, Easter, Matariki, Mothers’ Day, Anzac Day, Melbourne Cup and Christmas are celebrated.  Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Each resident has a leisure plan which is reviewed six-monthly at the same time as the care plan. Resident meetings are held two monthly and open to families to attend. Feedback on activities was positive from both residents and families interviewed. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial interim care plans are evaluated by the registered nurses within three weeks of admission and at least six monthly thereafter. Care plans are updated with other changes as they occur. A multidisciplinary conference is held (MDT) involving input from resident (as appropriate), relative, care staff, DT, physio, GP and other allied health professionals involved in the care of the resident. There is a record of the MDT meeting which records if the resident goals have been met or unmet and changes to care to meet the resident goals and resident/relative comments. There is at least a three-monthly review by the NP/GP. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on electronic resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the NP/GPs and responded to in a timely manner. Referrals and options for care were discussed with the family as evidenced in interviews and eCase medical notes. There is close liaison and good communication with dietitians, physiotherapists, podiatrist, mental health service for the older person, mental health and addictions team, speech language therapist, diabetes service and DHB nurse specialists. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available. There is a chemical mixing dispenser. There is one sluice room in the facility. Relevant staff have completed chemical safety training. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a building warrant of fitness status report issued (due to Covid) which expires 5 March 22. There is a full-time maintenance person Monday to Friday and available on-call and a gardener employed 12 hours a week. The maintenance person receives eCase notifications for maintenance requests and repairs. There are essential contractors available 24 hours. There is a monthly planned maintenance schedule that includes internal and external maintenance and resident equipment. Testing and tagging of electrical equipment is completed annually. Clinical equipment is calibrated annually. Resident hot water temperatures are randomly checked monthly. Corrective actions/re-checks have been documented for temperatures above 45 degrees Celsius. Refurbishment of rooms are done as they become vacant. New carpet and furniture have been purchased and there are planned renovations to communal and service areas in 2022.  The communal areas in the facility are readily accessible for residents using mobility aids and for hospital residents being transferred in in lounge chairs. The corridors are wide with rails. All seating was appropriately placed in communal lounge and dining areas. The external grounds and gardens were well maintained. There is safe ramp access to the outdoors for rest home/hospital residents with seating, shade and raised gardens There is a designated smoking area.  Healthcare assistants interviewed stated they have adequate equipment to safely deliver care for all residents. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There is a mix of ensuite and use of communal shower/toilets. All rooms have hand basins. Fixtures, fittings and flooring are appropriate. There is ample space in toilet and shower areas to accommodate shower chairs. Communal shower/toilet doors have privacy signs and shower curtains. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There are two double rooms. All other residents’ rooms are single. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large dining room, smaller dining room, large lounge and two smaller lounges including a TV lounge. There is library, recreational room and beauty salon. Activities occur in the recreational room or lounges. There are seating alcoves where residents who prefer quieter activities or visitors may sit. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There is a laundry on-site for the laundering of personal clothing. The laundry has a defined clean/dirty area. A housekeeping supervisor oversees the laundry and cleaning services. There is a laundry person on duty 9 am-2 pm seven days a week. All other laundry/linen is laundered off-site at a commercial laundry. This is a six day pick up of dirty laundry and six-day delivery. The pickup and delivery(separately) are from an external shed. There were adequate linen supplies available in linen storage areas throughout the facility.  There are two cleaners on duty Monday to Friday for five hours each and one housekeeper in the weekends. Cleaning trolleys have locked chemical boxes on them, and the trolleys are locked away in the cleaning room when not in use. All chemicals on the cleaner’s trolley were labelled correctly. The chemical provider monitors the effectiveness of chemicals used. Cleaning and laundry services are monitored through the internal auditing system. Staff have completed chemical safety training. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an emergency health management plan 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. There are first aid kits available in the van, kitchen and nurse’s station. Thornleigh Park has an approved fire evacuation plan in place. Fire evacuation drills occur six-monthly. Smoke alarms, sprinkler system and exit signs are in place.  The service has alternative cooking facilities (BBQ and gas hobs in the kitchen). The service has a backup system for emergency lighting and battery backup for up to four hours. 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 four- monthly. There is sufficient water (ceiling water tanks and bottled water) stored. Call bells are evident in residents’ rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitors’ book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms and communal areas have ample natural light and ventilation. Air conditioning units are in place. The facility is heated by central heating. Residents have oil filled heaters as required. Staff and residents interviewed stated the temperature of the facility was comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Radius Thornleigh has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPIs. The clinical manager is the designated infection control nurse with support from the registered nurses and the quality management committee (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme is reviewed annually by Radius head office. The infection rate trend documents a reducing trend for 2021. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The clinical manager at Thornleigh is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the quality management team and care staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.  Staff worked very hard during the Covid lockdown( s) to cover shifts; management team all took turns to man the reception desk in the weekends. The service monitored the health status and temperatures of staff at the commencement of each shift and also took temperature observations for all residents daily.  The service communicated through email updates, newsletters and zoom calls from the facility, to ensure family and friends of the facility felt connected and informed with the covid related information, residents wellbeing, activities, highlights of their day etc to ensure they did not worry about their residents/loved ones, while they could not visit.  To support staff through covid levels and changes the service provided lunches, treats such as chocolates, drinks, extra break times during shifts and discussed concerns at meetings.  There is Covid pandemic folder in place with planning, table top plan which gives an over view of outbreak planning is displayed in staff room and both nurses’ stations.  There is a comprehensive COVID Preparedness operational folder that has many resources, information, planning includes Flow charts, COVID testing instructions, Emergency Management Plan, Pandemic and Infectious disease Outbreak Plan. |
| Standard 3.3: Policies and procedures  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. | FA | There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Radius and the policies have been developed at head office. The infection prevention and control policies link to other documentation and cross reference where appropriate. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control nurse is responsible for coordinating/providing education and training to all staff. The infection control nurse has completed infection control training. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management training is provided both at orientation and as part of the annual training schedule. Infection control is an agenda item on the full facility and clinical meeting agenda. Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection control coordinator completes a monthly report. Monthly data is reported to the quality and staff meetings. Staff are informed of infection control through the variety of facility meetings. There have been two outbreaks since the previous audit. Both were managed well and reported to relevant authorities. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there were no residents using restraints and one resident using an enabler. The resident with an enabler care plan included interventions or risks associated with enablers. Staff training has been provided around restraint minimisation and managing challenging behaviours in August 2018. |

# 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.

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| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.