

Radius Residential Care Limited - Radius Millstream

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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Radius Residential Care Limited

Premises audited: Radius Millstream

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

Dates of audit: Start date: 5 April 2017 End date: 6 April 2017

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 72

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
Yellow	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
Red	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 Millstream is owned and operated by Radius Residential Care Limited and cares for up to 80 residents requiring rest home, hospital or dementia level of care. On the day of the audit there were 72 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 and the general practitioner.

The service is managed by a registered nurse with experience in aged care management. She is supported by an experienced clinical manager and regional manager/registered nurse. The service has been operating 10 months and all residents, relatives and the GP interviewed spoke positively about the service provided.

This audit has identified an area for improvement around internal audit corrective actions and neurological observations.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Policies and procedures adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Radius Millstream is part of the Radius group and as such, there are organisational wide processes to monitor performance. A facility manager and clinical manager are responsible for day-to-day operations. There is a quality system that is being implemented in line with the organisational quality plan. Management and quality, infection control and health and safety meetings are used to monitor quality activities such as audit, complaints, health and safety, infection control and restraint. Residents receive

services from suitably qualified staff. There is an adverse event reporting system implemented at Radius Millstream and monthly data collection monitors predetermined indicators. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments. There is a documented rationale for staffing the service. Registered nursing cover is provided 24 hours a day, 7 days a week.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Entry to the service is managed by the clinical manager/registered nurse. There is comprehensive service information available. Initial assessments are completed by a registered nurse. InterRAI assessments and long-term care plans are completed within 21 days of admission. Care plan evaluations are completed at least six-monthly. All clinical documentation including progress notes are entered into the electronic resident database that is accessible for all staff. Residents and family interviewed confirmed they were involved in the care planning and review process.

The activity programme is varied and interesting and includes outings, entertainment and links with the community and schools. Each resident has an individual activity plan programme. Activities are meaningful and meet the recreational needs of the rest home, hospital and dementia level of care residents.

Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Medications are prescribed and administered in line with appropriate guidelines and regulations. Medication charts are reviewed at least three-monthly by the resident's general practitioner.

All meals and baking is prepared on-site by contracted caterers. The menu is varied, appropriate and has been reviewed by a dietitian. Individual and special dietary needs are accommodated. Alternative options are provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current certificate of public use. There is an ongoing maintenance plan. Chemicals are stored safely throughout the facility. All bedrooms have access to an ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are lounge and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services. Laundry services are outsourced. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. There is a staff member on duty at all times with a current first aid certificate.

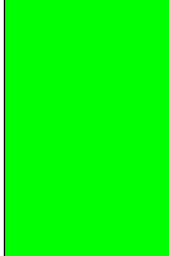
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator/clinical manager. During the audit, there were two residents using

enablers voluntarily and no residents with restraints. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. There is organisational benchmarking. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the opening of the facility.

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	43	0	2	0	0	0
Criteria	0	91	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Radius Millstream policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with six care staff (four healthcare assistants across the three service levels and two activities coordinators) confirmed their understanding of the Code. Five residents (three rest home level and two hospital level) and five relatives (one hospital level and four dementia level) interviewed confirmed that staff respect privacy and support residents in making choices.
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	Informed consent processes are discussed with residents (as appropriate) and families on admission. Written consents are signed by the resident or their enduring power of attorney (EPOA). Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Healthcare assistants (HCA) and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with five family members (four of dementia residents and one hospital relative) identified that the service actively involves them in decisions that affect their relative's lives. Nine of nine resident files sampled (three rest home, three dementia and three hospital including

		one respite care resident) had a signed admission agreement and consents.
<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	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on residents' family/whānau and chosen social networks. The Nationwide Health and Disability Advocacy Service is an invited speaker at resident/family meetings and staff training on the Code and the role of advocacy services.
<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	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Relatives and friends are encouraged to be involved with the service and care.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint's register that includes complaints received, dates and actions taken. There is evidence of lodged complaints being discussed in the facility (full staff) meetings. There was one complaint made in 2016 and five complaints have been received in 2017 year to date. The facility manager signs off each complaint when it is closed. Complaints are being managed in a timely manner and meeting requirements determined by Health and Disability Commissioner.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	There is an information pack given to prospective residents and families that includes information about the Code and the Nationwide Advocacy Service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of

		services and any liability for payment for items not included in the scope. This is included in the service agreement.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed personal privacy for residents is ensured. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Care staff interviewed could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with healthcare assistants described how choice is incorporated into resident cares.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The Māori health plan policy for the organisation references local Māori healthcare providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with community representative groups (e.g. Hukatere Marae) as requested by the resident/family. During the audit, there were no residents that identified as Māori living at the facility.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Nine resident files reviewed evidenced that individual beliefs or values are 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. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. The monthly facility (full staff) meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers (regional manager, facility manager and clinical manager) and care staff confirmed their awareness of professional boundaries.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Policies and procedures are aligned with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. An annual in-service training programme is implemented as per the training plan. Outcomes for the service are monitored with benchmarking across all Radius facilities. Feedback is provided to staff via the various meetings and through graphs and notices on the noticeboard in the staff room. There is a minimum of one RN on the night shift with additional RNs on the morning and afternoon shifts. A physiotherapist is available for two hours a week. Registered nurses and healthcare assistants were described by residents and family as being caring.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. Twelve adverse events reviewed met this requirement when notification was appropriate. Family members interviewed confirmed they are notified following a change of health status of their family member. Bi-monthly resident/relative meetings provide a venue where issues can be addressed. There is an interpreter policy in place and contact details of interpreters were available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Radius Millstream is part of the Radius group of facilities. The facility is a new purpose-built facility providing three levels of care (rest home, hospital and dementia) for up to 80 residents. The facility is all one level and divided into three self-contained units. One larger unit includes 40 dual purpose rest home/hospital beds. There is another smaller unit made up of 20 dual purpose rest home/hospital beds. The third unit is a secure 20 bed dementia unit. At the time of the audit, there were a total of 72 residents (32 rest home level residents, 24 hospital level residents- including 1 resident on respite and 16 residents in the dementia unit). All residents were under the Aged Related Residential Care (ARRC).</p> <p>Millstream Care Home has set a number of quality goals around the opening of the facility and these also link to the organisations strategic goals. Standardised policy and procedure, annual education programme, core competency assessments and orientation programmes are implemented at all sites. Radius has robust quality and risk management systems implemented across its facilities. A business plan April 2016- March 2019 has been developed and includes business plan targets for 2016/17.</p> <p>The facility manager is a qualified registered nurse (RN), has been in the role since September 2016 and has 10 years' experience in aged care management. A clinical manager/RN appointed in</p>

		<p>October 2016 supports her. The clinical manager has had clinical experience within the aged care environment. The facility manager and clinical manager are supported by a regional manager, who attended the audit for the two days.</p> <p>Radius provides a comprehensive orientation and training/support programme for their facility managers and clinical managers and regular forums for both occur across the year. The facility manager has maintained at least eight hours annually of professional development activities related to managing a hospital/rest home.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager/RN covers during the temporary absence of the facility manager. For extended absences, Radius has interim (roving) facility managers who cover facility manager absences. The regional manager is available on consultative basis.</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>There is an organisational quality/risk management plan that includes: clinical/care related risks; human resources; health and safety; environmental/service; financial; as well as site specific risks/goals identified for Radius Millstream. Quality and risk performance is reported across facility/quality meetings and to the regional manager. Discussions with the managers and staff reflected staff involvement in quality and risk management processes. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting.</p> <p>The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are implemented when opportunities for improvements are identified (eg, internal audit results are lower than 95% compliance). Not all internal audits lower than the 95% compliance had corrective actions initiated or completed. Resident and family meetings are held bi-monthly. The first annual resident/relative survey was completed in March 2017. The overall satisfaction result was at 92%. Results were collated and discussed with staff.</p> <p>The service has policies and procedures and associated implementation systems, adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level by the Clinical Managers Group with input from facility staff every two years. Clinical guidelines are in place to assist care staff.</p>

		<p>Updates to policies included procedures around the implementation of interRAI and health and safety to the new Act.</p> <p>Health and safety policies are implemented and monitored by the Health and Safety Committee. A health and safety representative (maintenance person) was interviewed about the health and safety programme. Health and safety representatives have completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>Falls prevention strategies are in place including sensor mats, perimeter mattresses and intentional rounding.</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. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. They are signed off by the facility manager or clinical manager when complete. A review of twelve accident/incident forms identified that forms are fully completed and include follow up by a registered nurse. However, not all neurological observations had been completed for suspected injury to the head (link 1.3.6.1). Accident/incident forms are completed when a pressure injury is identified. The facility manager and regional manager were able to identify situations that would be reported to statutory authorities including (but not limited to): infectious diseases, serious accidents and unexpected death.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (one facility manager, one clinical manager, two RNs, two healthcare assistants, one activities coordinator and one cleaner) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. An education and training plan is being implemented and includes in-service education and competency assessments. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies</p>

		<p>during their induction. These competencies are repeated annually.</p> <p>There is a total of 33 healthcare assistants. Nine healthcare assistants work in the dementia unit and four have completed the dementia standards. The other five healthcare assistants have commenced the standards and all have been at the facility for less than 12 months. Registered nurses are supported to maintain their professional competency. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. The facility manager and clinical manager, both RNs, work full-time Monday to Friday. The rest home/hospital units (thirty-two residents in the larger unit and twenty-four residents in the smaller unit) are staffed with two RNs on the morning and afternoon shifts and one on the night shift. Six healthcare assistants are scheduled to work during the morning and afternoon shifts and two are scheduled to work during the night shift.</p> <p>In the dementia unit (sixteen residents) there is one RN that covers the morning and afternoon shifts with the hospital RN on duty covering the night shift. The RNs are supported by two healthcare assistants on the morning and afternoon shifts and one on the night shift. Interviews with five residents and five relatives confirmed staffing overall was satisfactory.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files 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 on the computer based system. Information containing personal resident information is entered into an electronic system which is confidential and cannot be accessed by unauthorised personnel. Entries into the computer based system are able to be identified, dated and timed.</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. Residents/relatives receive an information pack outlining services able to be provided. The clinical manager screens potential residents to ensure their needs can be met by the service. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the clinical manager. The admission agreement aligns with the requirements of the ARCC. Exclusions from the service are included in 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>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</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>	<p>FA</p>	<p>There are medication management policies and procedures that comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication round sighted. Registered nurses and HCAs who administer medications have completed annual medication competencies and medication education. Medications are checked by an RN on delivery. Eye drops had been dated on opening. All medications were within the expiry dates. The medication fridge temperature is monitored and within acceptable limits. There was one self-medicating resident with a self-medication competency in place that has been reviewed three-monthly. The medication is stored safely in the resident room.</p> <p>Medication charts are hand written by the GPs and meet legislative prescribing requirements for regular and 'as required' medications. Medication charts had photo identification and allergy status identified. The GP reviews the medication charts at least three-monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a fully functional kitchen and all food is cooked on-site by a contracted service. The kitchen manager (chef) is responsible for the daily meal service. Food services staff have completed food safety training and chemical safety training. The summer and winter menus have been reviewed by a dietitian. The food is transported in hot boxes to the kitchenettes where food is served from bain maries. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. The chef is notified of any changes to resident's dietary requirements. Resident dislikes are known and accommodated. Special diets accommodated include gluten free, dairy free, diabetic desserts and modified/pureed diets. Meals observed on the day of audit were well presented including pureed meals.</p> <p>The temperatures of refrigerators, freezers, end cooked foods and serving temperatures are monitored and recorded daily. All food is stored appropriately and dated. Chemicals are stored in a locked cupboard. A cleaning schedule is maintained.</p> <p>Residents and the family members interviewed were satisfied 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	The service records the reason for declining service entry to residents should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	All appropriate personal needs information is gathered during admission in consultation with the resident (where appropriate) and their relative. Risk assessment tools are completed and the outcomes are reflected in the care plans. InterRAI assessment tools have been completed within twenty-one days of admission and six-monthly for the eight long-term resident files reviewed. Care plans reviewed were developed on the basis of these assessments.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Care plans reviewed on the electronic resident based system described in detail the support required to meet the resident's goals and needs as identified through the assessment process. The involvement of allied health professionals was identified in the care plans. Residents and their family/whānau are involved in the care planning and review process as confirmed on interview and documented in the interRAI assessment. This was also documented on the contact with family page on the electronic resident based system. Care plans are updated to reflect changes to care and supports. Staff interviewed reported they had access to the electronic system and care plans.
<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>	PA Low	<p>Registered nurses (RNs) and healthcare assistants follow the detailed electronic care plans and report progress against the care plan each shift. If external nursing or allied health advice is required, the RNs will initiate a referral. If external medical advice is required, this will be actioned by the GP. Families confirmed on interview that they are kept informed of health changes and this communication is entered into the electronic system.</p> <p>Staff have access to sufficient medical supplies. Sufficient continence products are available and resident electronic file includes a continence assessment and plan as appropriate. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessments, wound management plans and evaluations were viewed on the electronic resident based system for skin tears, two chronic wounds and one surgical wound. There were no</p>

		<p>pressure injuries on the day of audit. Two recently healed stage I pressure injuries were being monitored daily. The RNs have access to specialist nursing wound care management advice through the DHB.</p> <p>Neurological observations had been commenced post unwitnessed falls, however not all observations had been completed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There are three activity coordinators (two work 37.5 hours per week and one 20 hours per week) to coordinate and implement the Monday to Friday programme in the rest home/hospital units and dementia care unit. On three days of the week, there are three activity coordinators on duty ensuring all three units have activities happening throughout the day, as observed during the audit. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. One-on-one time is spent with residents who choose not to or unable to participate in group activities. Group activities are integrated and occur in both rest home/hospital lounges. The activities in the dementia unit are based on meaningful activities including home-based activities, pet therapy and reminiscing.</p> <p>Entertainers, guest speakers, pre-school children and other community groups visit the home. Church services are held regularly. Group activities reflect ordinary patterns of life and include planned visits to the community, including a seniors group, blind foundation and other clubs/groups. The service has a wheelchair van for outings.</p> <p>Resident files reviewed have a life history profile and leisure activity plan that is evaluated at least six-monthly. Residents and families interviewed commented positively on the activity programme. Residents have an opportunity to feedback on the programme through the resident action group that meet fortnightly and the resident meetings held two-monthly, taken by the Age Concern advocate.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial (interim) care plans are evaluated by the registered nurses within three weeks of admission. In files reviewed on the electronic system the long-term care plans had been evaluated at least six-monthly or earlier if there is a change in health status. There is at least a three-monthly review by the GP. All changes in health status are updated on the electronic care plans. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health</p>

<p>(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>		<p>services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and electronic notes. There was evidence of a re-assessment where a resident's condition had changed and required a higher level of care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are implemented policies in place to guide staff in waste management. 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. There is no decanting of chemicals. Safety data sheets are available. The chemical provider monitors the use of chemicals and provides chemical safety training for all staff. Each unit has a sluice room accessible by swipe card.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building currently has a certificate for public use (CPU) which expires 4 July 2017. There is a full-time and on-call maintenance person employed to address the reactive and planned maintenance programme. Essential contractors are available 24 hours. Hot water temperatures are monitored at least monthly and maintained below 45 degrees Celsius. All medical and electrical equipment was purchased new and not yet due for electrical testing or calibration.</p> <p>The facility has sufficient space for residents to mobilise using mobility aids in all units. The external area is well maintained. The dual-purpose units have access to external courtyards, seating and shade.</p> <p>The dementia unit has a safe external courtyard with seating with free access through two exit/entry doors.</p> <p>Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	<p>FA</p>	<p>All bedrooms have ensuites. There are communal toilets located near the communal areas. There is a large shower room which can accommodate a tilting shower chair if required. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>

facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<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>There are three double rooms (one in dementia care and two rest home/hospital). All other resident rooms are single.</p> <p>There is sufficient space for the safe use and manoeuvring of mobility aids, including those required by hospital level care residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. Some rooms in all units open out onto the courtyards.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The two rest home/hospital units have open plan dining and lounge areas. There is an activities room in the 40-bed rest home/hospital unit. There is an additional smaller lounge within the 20-bed rest home/hospital unit. There are seating alcoves within the facility. The communal areas are safe and accessible for residents.</p> <p>There is an open plan dining room with two separate lounge areas. Seating is appropriately placed for individual or small group activities.</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 is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme and through the chemical provider who visits monthly. Cleaning trolleys are kept in locked areas when not in use.</p> <p>All laundry is laundered off-site at a commercial laundry. There are laundry pick-up and delivery four days per week and more often if required. There was an adequate supply of linen sighted in storage areas in the three units on the day of audit. There is a laundry with an entry and exit door with defined clean and dirty areas of the laundry. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility and the laundry service.</p>
Standard 1.4.7: Essential,	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. There is a minimum of one first aid trained staff member on every shift and during outings. The</p>

<p>Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>facility has an approved fire evacuation plan. Fire drills take place every six months. The last fire evacuation drill occurred on 21 March 2017. Smoke alarms, sprinkler system and exit signs are in place. Emergency lighting is in place which is regularly tested. A civil defence kit is in place. Supplies of stored water and food are held on-site and are adequate for three days. Electronic call bells are evident in resident's rooms, lounge areas and toilets/bathrooms. The facility is kept locked from dusk to dawn.</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. There is underfloor heating throughout the facility. Resident rooms are individually heated. 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 Millstream has an established infection control programme (last review November 2016). The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the designated infection control nurse with support from the clinical manager and regional manager (RN).</p> <p>Visitors are asked not to visit if they are unwell. There are hand sanitisers appropriately placed throughout the facility. Outbreak kits are readily 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>A registered nurse is the designated infection control (IC) coordinator since January 2017 and is being mentored by the clinical manager who held the role previously. Both have attended education via teleconference with an infection control specialist/microbiologist. There are adequate resources to implement the infection control programme.</p> <p>The IC coordinator has good external support from the local laboratory, IC nurse specialist at the DHB, the infection control nurses group and the GP's.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures</p>	FA	<p>There are Radius infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team</p>

<p>for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed in November 2016.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred annually. Staff who are unable to attend view a power-point presentation and complete a questionnaire. A practical hand washing competency is completed on orientation and annually. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>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.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in Radius's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Infection work logs are generated through the electronic resident database. Surveillance of all infections is entered on to a monthly infection register. This data is monitored and evaluated monthly and annually and provided to Radius head office. Infections are part of the key performance indicators (KPI). Quality improvements are raised for any infection rates above the KPI. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The nurse manager is the restraint coordinator. There were no residents on restraint and two hospital level residents with enablers on the day of audit. Two resident files were reviewed where enablers (bedrails) were in use. Voluntary consent and an assessment process were completed. The enabler is linked to the resident's care plan and is reviewed three-monthly. Staff complete restraint questionnaires and education annually.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are implemented when opportunities for improvements are identified (eg, internal audit results are lower than 95% compliance). Not all internal audits lower than the 95% compliance had corrective actions initiated or completed.	There was no documented evidence of corrective action plans being initiated or completed for three clinical internal audits that were below the organisational compliance threshold (95%).	<p>Ensure that all internal audits that are below the organisational compliance threshold have corrective action plans completed.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of</p>	PA Low	Monitoring charts include: intentional rounding, turning charts, food and fluid charts, observations, weight, behaviour and pain monitoring. Abbey pain assessments had been completed for	Neurological observations had been commenced for four unwitnessed falls (three	Ensure neurological observations

<p>services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>residents unable to verbalise pain. Neurological observations are required for unwitnessed falls for obvious or unknown head injuries. Not all neurological observations viewed had been completed.</p>	<p>dementia level of care residents and one hospital level of care resident), however the neurological observations had not been completed as per policy</p>	<p>are completed as per policy timeframes. 90 days</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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.