# Radius Residential Care Limited - Radius Glaisdale

## 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](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 Glaisdale

**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: 28 March 2018 End date: 29 March 2018

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 63

# 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

Radius Glaisdale is owned and operated by Radius Residential Care Limited. The service has been operating for nine months in a new purpose-built facility and provides care for 80 residents requiring rest home, hospital or dementia level care. On the day of the audit there were 63 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 residents’ and staff files, observations and interviews with residents, relatives, staff, management, general practitioner and physiotherapist.

The service is managed by a facility manager/registered nurse with previous experience in aged care clinical management. She is supported by a Radius regional manager and a clinical manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

This audit has identified an area for improvement around communication, interventions and aspects of medicine management.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

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

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

There are organisational-wide processes to monitor performance, with additional support provided to assist this new facility. The service is managed by appropriately trained personnel and there is a suitable structure in place to oversee service delivery in the absence of the manager. There is an adverse event reporting system implemented. Monthly data collection and analysis is undertaken, and results are made known to staff. There is a human resource manual to guide practice. Staff files were reviewed; all had a current appraisal and showed human resource practices are followed. There is a documented rationale for staffing the service. Staffing rosters were sighted and healthcare assistant staff on duty match needs of different shifts. Resident information is kept confidential and old records are archived.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Entry to the service is managed primarily by the facility manager/registered nurse. There is comprehensive service information available on the three service levels of care. Initial assessments are completed by a registered nurse. Care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans and worklogs (developed on the electronic resident system) are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process. The general practitioner reviews residents at least three monthly. There is allied health professional involvement in the care of the residents.

The activity programme is varied and interesting and includes outings, entertainment and links with the community. Each resident has an individual leisure care plan. The rest home and hospital have an integrated programme. The activities in the dementia unit are flexible and meaningful.

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.

Meals and baking are prepared on-site by a contracted service. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. There are nutritious snacks available 24 hours.

## Safe and appropriate environment

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

The building has a current certificate for public use. There is a reactive and maintenance plan. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy with ensuites. There are communal toilet/showering facilities available. 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 for each area are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services. 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 at least one staff member on duty at all times with a 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. |

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were no residents with restraints or enablers at the time of audit.

## Infection prevention and control

|  |  |  |
| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

There are infection control management systems in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. The infection control coordinator has attended external education. Relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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 | 42 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 90 | 0 | 2 | 1 | 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 | Radius Glaisdale has an implemented code of rights policy and procedure. Discussions with staff including; five healthcare assistants (three rest home/hospital and two dementia), two registered nurses, one enrolled nurse, one diversional therapist and one cook. Also, two regional managers, one acting clinical manager (CM) and one facility manager, identified their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights ‘the Code’. Interviews with four residents (two hospital and two rest home) and eight relatives (five hospital, one dementia and two rest home) confirmed service is provided in line with the Code. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. Consent forms, advance directives and copies of enduring power of attorney (EPOA), where applicable, were seen on each individual electronic resident database (e-case) in the nine resident files reviewed (three rest home, four hospital including one younger person under long-term chronic health condition and two dementia level of care residents). There is evidence of general practitioner discussion with family regarding resuscitation as evidenced in the e-case progress notes.  Health care assistants, enrolled nurse (EN) and registered nurses (RN) interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives.  All nine resident files reviewed had a signed admission agreement. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | There is an advocacy policy and procedure that includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy and advocacy pamphlets are available at reception. Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.  The resident file includes information on resident’s family/whānau and chosen social networks.  Discussion with relatives identified that the service has made improvements regarding opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions and they are happy with the level of involvement currently. |
| 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 | The client information pack informs that visiting can occur at any reasonable time. Interviews with residents and relatives confirmed that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and procedure states that clients/family/whānau shall have access to a complaints system whereby they can express concern without prejudice and those concerns are addressed. Residents/family can lodge formal or informal complaints through verbal communication, written, resident meetings, and complaint forms or via suggestion box. Complaints information and forms are included in the information pack provided to residents and relatives at entry.  The complaints log/register includes date of incident, complainant, summary of complaint, and sign-off as complete.  There have been 21 complaints year-to-date, including three complaints with DHB involvement, aspects of these complaints have been partially substantiated by the DHB. Many aspects of the complaints have been closed off. The service continues to work with the DHB to ensure that all aspects of the complaints are followed up.  Following complaints Radius introduced a senior management team to support the service commencing January/February 2018. A new facility manager (acting manager at the time) a regional manager and an experienced acting clinical manager reviewed all complaints as part of the service improvement and documented an action plan (if needed) for all complaints. Individual action plans all document follow-up until the action plan had been completed. Individual complaint action plans have been linked to the services overarching service improvement action plan (link to 1.2.3 for improvements in quality process and follow-up). These action plans are reviewed monthly to ensure follow-up. Families interviewed (including two of the complainants) agreed that the service is improving and that complaints have been largely addressed. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service provides information to residents that includes the code of rights, complaints and advocacy information. Information is given to next of kin or EPOA to read to and/or discuss with the resident. Interviews with residents and relatives identified they are well informed about the code of rights. There is a specific information pack for families and residents in the dementia unit.  The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet, advocacy and H&D Commission information. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has a philosophy that promotes quality of life and involves residents in decisions about their care, respects their rights and maintains privacy and individuality.  Contact details of any spiritual/religious advisors are available to staff. Religious dietary requirements identified through assessment and care planning are met as required. Discussions with residents and relatives confirmed the staff are respectful and that their privacy is respected, and that cultural and/or spiritual values and individual preferences are identified. Care plans reviewed identified specific individual likes and dislikes.  There is an implemented abuse & neglect policy that staff have completed training around as part of orientation, and could describe appropriate practices to prevent and identify any abuse or neglect. Ongoing training is planned, as part of the Radius annual training plan. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There is a specific Māori health care plan and a culturally safe care policy. The service has one resident who identifies as Māori. They have a culturally appropriate care plan. There are five staff who identify as Māori.  Discussions with staff confirmed an understanding of the different cultural needs of residents and their whānau. There is a section in the electronic assessment and care plan that includes spirituality, religion and culture, psycho-social needs and family and significant others. The service also utilises local iwi when required for support and advice and a Kaumātua who provides support to staff and residents. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Care planning includes consideration of spiritual, psychological and social needs. Residents indicated that they are involved in the identification of spiritual, religious and/or cultural beliefs. Relatives interviewed stated that they felt they were consulted. Family involvement is encouraged (eg, invitation to facility functions). One European resident (English is a second language) said communication was very good.  Care plans reviewed included the residents’ social, spiritual, cultural and recreational needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There is a comprehensive and implemented discrimination and harassment policy in place. There is a staff policy in relation to gifts and gratuities and the management of external harassment. Residents interviewed felt that they were not exposed to exploitation.  A staff employment handbook and orientation package include a code of behaviour, code of conduct, and a non-disclosure agreement. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The comprehensive orientation programme provided to staff on induction includes dignity and privacy. Interviews with staff informed an understanding of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Services are provided at Radius Glaisdale that adhere to the Heath & Disability Services Standards (2008) and all required legislation and guidelines are adhered to. The service has implemented policies and procedures to provide assurance it is adhering to relevant standards. Policies are reviewed and approved by the clinical management committee at an organisational level. The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility.  Staff are informed when external training is available and financial support is considered. There is support available for those wishing to pursue postgraduate qualifications (appropriate to the area of work). There is access to computer and internet resources and search engines. There is organisational membership to Bug Control for infection control updates/training and expert advice.  The service opened last June, and since November 2017 the service has proactively followed up on any service gaps identified through internal audits, external review and complaints feedback. There are comprehensive action plans in place, service support from a senior team and additional education and support provided for staff. The GP and relatives reported positively on improvements to service. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | Ten incident reports were reviewed across the service but not all recorded family notification. Relatives informed they are notified of any changes in their family member’s health status.  The facility has an interpreter policy to guide staff in accessing interpreter services. There are no residents who currently require an interpreter. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.  Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health ‘Long-term Residential Care in a Rest Home or Hospital – what you need to know’ is provided to residents on entry. The information pack is available in large print and advised that this can be read to residents. The information pack and admission agreement included payment for items not included in the services. A site-specific booklet; ‘Introduction to dementia unit’ provides information for family, friends and visitors to the facility. The enquiry pack provides practical information for residents and their families. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Radius Glaisdale is a new, purpose-built Radius aged care facility that opened June 2017. The facility is certified to provide hospital services (medical and geriatric services), rest home care and dementia care for up to 80 residents. On the day of the audit there were 63 residents. The 60-bed rest home and hospital (all dual-purpose beds) included: 17 hospital level residents (including one younger person under the long-term chronic condition contract and one privately paying) and 33 residents at rest home level. The 20-bed secure dementia unit included 13 residents.  The service has a business plan that describes the vision, values and objectives, which includes a person-centred approach. Radius Glaisdale also has a comprehensive action plan in place to ensure that this new facility continues to develop according the Radius philosophy. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.  Review of the business plan, quality plan and action plans reflect regular reviews via regular meetings and monthly reports to the regional manager.  Since its opening Radius Glaisdale has had a change of management team as well as additional support from the Radius senior management team to assist the growth of the facility and establishing processes and systems. The current management team includes; the regional manager who is on-site three to five days a week and another regional manager on-site five days a week. The facility manager (FM) was seconded from another Radius home during February and has recently accepted a permanent position at Glaisdale as permanent facility manager. The FM is a registered nurse with aged care management experience. The permanent clinical manager (away on the day of audit) is assisted by an experienced relieving clinical manager.  The facility manager has maintained at least eight hours of professional development activities related to managing an aged care facility. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | During the temporary absence of the facility manager, the service is managed by one of the regional managers with support from the clinical manager. Radius has roving clinical managers and roving managers who can provide support during absences. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is an organisational quality/risk management plan that includes: clinical/care related risks, human resources, health and safety, environmental/service, financial as well as site-specific risks/goals identified.  Following the opening of the service (June 2017), there have been a series of complaints around service provision, including three DHB complaints. Radius has responded with increased management support, an internal review, staff training and support and an in-depth action plan. The action plan links to identified service gaps and documented monthly (or more often) reviews and updates. Management meetings include; head of department meetings, and daily catch ups.  Radius Glaisdale has also met with the DHB regularly. Relatives, the GP and residents interviewed all commented on the improvements to service.  There are policies and procedures appropriate for service delivery. Policy manuals are reviewed two yearly. New/updated policies are sent from head office. New policies/procedures are put in the staffroom with a signing sheet for staff to sign once they have read and understood the documentation.  Quality data including collection of monthly accident/incident and infection surveillance data, resident/relative surveys and internal audits are conducted, and corrective action plans are developed and implemented when service shortfalls are identified. There are regular quality meetings that include; health and safety, internal audits, incidents and accidents and infection control. Registered staff and staff meetings have been held with quality data and corrective action plans also discussed at these meetings. Resident/relative meetings are held monthly to two monthly.  There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The facility manager is the identified health and safety coordinator. Staff and contractors are orientated to health and safety issues and staff. The health and safety team identify and report hazards on hazard forms, which are then eliminated or minimised and added to the regularly reviewed hazard register.  Falls prevention strategies for individual residents such as sensor mats, low beds, landing mats, specialised chairs and intentional rounding are implemented and were described by staff interviewed. |
| 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 | When an incident occurs the healthcare assistant (or staff discovering the incident) completes the form and the RN undertakes an initial assessment and logs the incident onto the electronic system. The RN notifies family and GP as required (link to 1.1.9.1). The clinical manager collects incident reports daily and reviews both the incident and actions taken. There is evidence of proactive follow-up to incidents reviewed for February 2018. Ten incident forms sampled evidenced detailed investigations and corrective action plans following incidents. Incident reports are discussed daily at management updates and at monthly quality meetings.  The staff interviewed could describe the process for management and reporting of incidents and accidents.  Discussions with the regional manager(s) and facility manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. Notifications have been made around three pressure injuries. The service links closely with the DHB. |
| 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 | Nine staff files were reviewed (three registered nurses, four health care assistants, one house keeper and one activities person). All files reviewed had appropriate employment and human resource documentation, including interview and reference check documentation, employment contracts and job descriptions. There is a register for staff competencies that shows all competencies are current. Practising certificates were sighted for registered nurses, the enrolled nurse, GPs, physiotherapist, pharmacy, podiatrist and dietitian.  The organisation has a staff orientation policy. All staff files documented an orientation programme that is specific to worker type. Staff interviewed confirmed that all staff employed have an orientation period and that this is extended if required. The service has an internal training programme directed by head office that covers all required topics. The service has provided a wide range of additional training and toolbox talks related to issues raised by incident forms, complaints and any other service gaps identified.  There are 14 healthcare assistants who work in the dementia unit and of these, 13 have completed the required dementia standards and the other one has commenced the training.  Registered staff are supported to attend internal and external training to maintain current practice. Of the seven registered nurses, four are interRAI trained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an acuity and clinical staffing ratio policy in place that includes a documented rationale for staffing the service. The facility manager and relieving nurse manager, both are registered nurses, work full time and share on-call responsibilities. Additional support is also provided by a regional manager (Monday to Friday) and this region’s regional manager. A trainer is also employed 15 hours a week to assist with the full implementation of the electronic care planning system  Staffing in each unit is as follows:  Dementia unit: Currently 13 of a potential 20 residents – There is a registered nurse on duty shared with ‘B’ team. The RN is allocated for two hours AM and three hours PM. In practice the RN comes into the dementia unit at least three times a day to check on residents and support staff. Healthcare assistants in the dementia unit said that the RN is readily available and supportive.  On morning shifts two healthcare assistants work a full shift. On afternoon shifts two healthcare assistants work a full shift. On night shift, there is one healthcare assistant.  Hospital unit, team ‘A’: Currently 27 of a potential 32 residents (11 hospital and 16 rest home) – The facility manager informs that staff can increase with acuity and/or resident numbers. There is a registered nurse on duty 24 hours per day in this unit.  On morning shifts three healthcare assistants work a full shift. On afternoon shifts three healthcare assistants work a full shift. On night shift, there is one healthcare assistant.  Hospital unit, team ‘B’: Currently 23 residents (six hospital and 17 rest home) of a potential 32 residents – The facility manager informs that staff can increase with acuity and/or resident numbers. There is a registered nurse on duty 24 hours per day in this unit (also providing oversight of the dementia unit which is adjoined to this wing).  On morning shifts three healthcare assistants work a full shift. On afternoon shifts three healthcare assistants work a full shift. On night shift, there is one healthcare assistant.  Staff interviewed stated that there is adequate staffing to manage their workload. When staff are absent and a replacement cannot be found from the current staff, agency staff are used.  There is a physiotherapist employed 12 hours a week and a physiotherapy assistant, 20 hours a week  Residents interviewed confirmed that there are sufficient staff on-site at all times and staff are approachable and in their opinion, competent and friendly. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents’ individual electronic record and service register.  Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Informed consent is obtained from residents/family/whānau on admission, for permission to display the resident’s name and taking of photographs.  Entries in resident files sampled were legible, dated and have an electronic signature by the relevant caregiver or RN including designation. All resident records contain the name of resident and the person completing the form/entry.  Individual resident files demonstrated service integration that also contains GP notes and the allied health professionals and specialist’s records if applicable. |
| 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 | The service has comprehensive admission policies and processes in place. Residents receive a welcome pack outlining services able to be provided, the admission process and entry to the service. The welcome pack includes specific information on the secure dementia care unit. The facility manager/registered nurse or clinical manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager. The admission agreement aligns with the requirements of the ARCC. 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. 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. Residents in hospital or on social leave are identified and monitored through the e-case 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. | PA Moderate | The medication management policies and procedures comply with medication legislation and guidelines. Registered nurses, enrolled nurse and senior HCAs administer medications and have completed medication competencies and medication education. Medication administration was observed in the hospital and the dementia care unit. Administration practice was compliant against the administration policy. Medications are delivered in robotic rolls, however there is no documented evidence that these have been checked against the medication chart. Each unit has a medication room. All pharmaceutical supplies are stored in the main hospital medication room with a bulk supply order for hospital level residents only. Not all medications were within the expiry date. The medication fridges are monitored and all temperatures were within the acceptable range. All eyedrops in use were dated on opening. There was one self-medicating resident in the rest home. A self-medicating assessment had been completed and monitoring of medication occurred each shift.  Eighteen medication charts (paper-based) were reviewed (eight hospital, six rest home and four dementia care) overall met prescribing requirements but the allergy status had not been identified on all charts. |
| 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 | There is a fully functional kitchen located within the service area of the building. All food and baking is prepared and cooked on-site by a contracted service. The co-owner/director (interviewed) visits the site fortnightly. The chef/kitchen manager has been employed since February and holds a diploma in hotel management and level four cookery qualification. He is supported by a second chef and kitchen assistants who have all completed food safety training. The co-owner/director develops the menu plan which is then reviewed by Dietitians NZ. Recipes and ordering is done on-line. There is a four-weekly winter and summer menu that includes a vegetarian option. Pureed foods, diabetic desserts, food allergies, likes and dislikes are accommodated. There is special equipment available for residents if required. Meals are plated and delivered in hot/cold boxes (as applicable to the unit kitchenettes). End-cooked temperatures and hot/cold box temperatures are monitored. 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.  The temperatures of refrigerators, freezers and chiller are monitored and recorded twice daily. The chemical provider checks and monitors the performance of the dishwasher. All food is stored appropriately and dated. A cleaning schedule is maintained. The current food control plan was issued 23 August 2017.  Residents and the family members interviewed commented positively about the quality and variety of food served. |
| 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 decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. |
| 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, homecare interRAI assessments and GP medical notes are used to develop the initial interim care plan within 24 hours. Appropriate assessment tools have been completed on the e-case and reviewed at least six monthly or when there was a change to a resident’s health condition, in files sampled. Electronic care plans are developed on the outcomes of these assessments. 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. | PA Low | Overall, the long-term care plans reviewed described the support required to meet the residents’ goals as identified by the ongoing assessment process and needs with exception to weight loss and de escalation techniques. Allied health involvement was linked to the long-term care plans. 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. Short-term care plans are in use for changes in health status and easily accessed on the electronic e-case system. Care requirements are generated into the care staff worklog. Staff interviewed reported they found the plans easy to follow and readily available. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Registered nurses (RNs) and HCAs follow the detailed and regularly updated care plans and report progress against the care requirements each shift. If a resident’s health status changes the RN initiates a GP or nurse specialist review. Relatives interviewed state they are contacted for any changes in the resident’s health (link 1.1.9.1).  Staff have access to sufficient medical supplies including dressings. Wound assessment and care plans, wound review plans and evaluation notes were in place for residents with wounds. Wound documentation was complete. There were three hospital residents with pressure injuries (resident with three healing stage pressure injuries, one resident with two healing unstageable pressure injuries and one resident with four stage one pressure injuries). Residents with stage three and unstageable pressure injuries were community acquired. There had been GP input for Pis. The unstageable PI came from hospital and had prior input from wound nurse specialist prior to admission to Glaisdale. RNs (interviewed) have access to specialist nursing wound care management advice through the district nursing service.  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, for example, turning charts, food and fluid charts, blood pressure, weight charts, behaviour charts, blood sugar levels and neurological observations, however a shortfall was identified around care plan interventions related to weight loss and behaviours (link 1.3.5.2). |
| 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 | A registered diversional therapist (DT) has been in the role for two weeks and is employed Monday to Friday 9.00 am – 4.30 pm. The DT is based in the rest home/hospital and oversees the activity programme for the dementia care unit. An activity assistant is employed in the dementia unit Monday to Friday 8.30 am – 5.30 pm. Healthcare assistants in the dementia unit incorporate activities for residents into their duty. The rest home and hospital programme is integrated and includes music, board games, trivia, newspaper reading, baking, arts, movies and happy hours. One-on-one time is spent with residents who choose not to or are unable to participate in group activities. There are regular exercise groups, walks, entertainment and van outings. The one younger person is supported to attend activities of their choice including shopping and attending appointments. Community visitors include volunteers, church services and pet therapy. Residents from the dementia unit attend group activities in the rest home/hospital as appropriate and under supervision. The activity programme for dementia care residents is flexible and focused on meaningful activities, small group activities and one-on-one time.  All resident files reviewed have an individual recreational assessment and activity plan that is evaluated at least six monthly. Residents and families interviewed commented positively on the activity programme. Residents have the opportunity to feedback on the activity programme through resident meetings. |
| 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. In the electronic files (two hospital and one rest home resident who had been at the service six month), the long-term care plan was evaluated at least six monthly. Two rest home, two hospital and two dementia care resident files reviewed had not been at the service long enough for a six monthly evaluation. There is at least a three-monthly review by the GP. Written evaluations identify if the resident/relative goals are met or unmet. Short-term care plans sighted on e-case have been evaluated and resolved or added to the applicable long-term care plan if the problem is ongoing. |
| 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 nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs and responded to in a timely manner. Referrals and options for care were discussed with the family as evidenced in interviews and e-case medical notes. The staff provided examples of where a resident’s condition had changed and the resident was reassessed. Examples of close liaison with dietitians, physiotherapists, podiatrist, mental health service for the older person, assessment and rehabilitation team and diabetes service were sighted in electronic resident files reviewed. |
| 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. 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 single storey building has a current certificate for public use (CPU), which was issued 13 September 2017. The maintenance person (based at another Radius site) is on-site two mornings a week at Glaisdale. Repairs and maintenance requests are generated through the e-case maintenance log, which is then actioned and logged. Monthly planned maintenance is completed as per the planned maintenance schedule including building warrant of fitness checks and hot water temperatures. All clinical equipment and electrical equipment was purchased new and not due for annual checks. The maintenance person is available to visit the site at any time for facility matters and is on-call. Essential contractors are available 24 hours.  The facility has wide corridors and rails for residents to mobilise safely using mobility aids. The external areas and courtyards are well landscaped. Residents have access to safely designed external areas that have seating and shade.  The dementia unit has a spacious outdoor courtyard with a safe walking pathway that has several entry/exit doors. Seating and shade is provided.  Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| 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 | All bedrooms have full ensuites. There are adequate numbers of toilets located near communal areas. There is a large shower room in the hospital that can accommodate a shower trolley if required. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| 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 | All resident rooms are single. There are 60 dual-purpose rooms that are of an appropriate size to allow rest home or hospital level of care. There is sufficient space for the safe use and manoeuvring of mobility aids and hoists. Resident rooms in the 20-bed dementia care unit are spacious. 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 are open plan dining and lounge areas in each unit (rest home, hospital and dementia unit). Each unit has a smaller quiet lounge for visitors or activities. There are seating alcoves throughout the facility. The communal areas are easily and safely accessible for residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All linen and personal clothing is outsourced. The laundry area is spacious, with one commercial washing machine and dryer, as the cleaning/laundry person launders delicates and woollens. The laundry has entry and exit doors located near the delivery entrance. There is a defined clean/dirty area in the laundry. There are two dedicated cleaning/laundry persons on duty each day.  They have access to a range of chemicals through a mixing system, cleaning equipment and protective clothing. Safety datasheets and product information is available. Cleaning trolleys are kept in locked areas when not in use.  Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility and the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster manuals to guide staff in managing emergencies and disasters.  All registered nurses are first aid trained.  The facility has a fire evacuation plan that has been approved by the fire service (letter from Fire Service dated 20 March 2017 sighted).  A fire drill was provided as part of induction and December 2017 (six monthly).  Smoke alarms, sprinkler system and exit signs are in place.  A gas barbeque and torches are available in the event of a power failure.  Emergency lighting is in place.  A civil defence kit is in place and stored in an accessible area.  Four thousand litres of stored water is available in tanks.  Electronic call bells are evident in resident’s rooms, lounge areas and toilets/bathrooms. There are security policies around locking of the facility from dusk to dawn. |
| 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 | General living areas and all resident rooms are appropriately heated and ventilated. Heat pumps are used in communal areas. Resident rooms have individual heat pump/air conditioning units. All rooms have external windows that open allowing plenty of natural sunlight. |
| 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 Glaisdale has implemented the Radius infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPIs. The facility manager (RN) is the designated infection control nurse with support from the clinical manager and DHB infection control service. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Radius infection control programme is reviewed annually at organisational level. |
| 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 facility manager (RN) is the IC nurse and is aware of the need to analyse data and the reasons behind this. The IC nurse receives ongoing education and completed Bug control training 2016. She is supported by the IC nurse at a sister Radius facility, the GP, the DHB resource person or Bug Control. |
| 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 | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. The infection control policies link to other documentation and uses references where appropriate.  Infection control policies are reviewed as part of the policy review process by Radius. Input is sought from facilities when reviewing policies. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The IC nurse ensures training is provided to staff through orientation and additional training. Informal education is also provided; availability of education was confirmed by healthcare assistants interviewed.  The orientation package includes specific training around hand washing and standard precautions. Hand washing is an annual competency (viewed on staff files).  Resident education is expected to occur as part of providing daily cares. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme. The service submits data monthly to Radius head office where benchmarking is completed.  Infections are collated monthly, including urinary tract, upper respiratory and skin. This data is analysed for trends and the raw clinical indicator data is reported to the quality, RN and staff meetings.  There have been no outbreaks since opening. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked.  There is a regional restraint group at the organisational level and a restraint group at the facility, where restraint is reviewed.  There were no residents with enablers or restraints at the time of the audit. Training around restraint minimisation, enablers and challenging behaviour has been provided as part of the orientation for all new staff. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | There is an open disclosure policy in place. Families interviewed said they have been informed if any issues. This information is not always documented. | Two of ten resident falls-related incident forms did not document if the relatives had been informed. A review of progress notes also, did not document this communication (both rest home residents). | Ensure that family communication is documented post incidents.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Medicines are appropriately stored in accordance with relevant guidelines and legislation. There was no documented evidence that medications had been checked on delivery against the medication charts and no system in place for the checking of expiry dates. Medication charts were legible and met prescribing requirements with indications for ‘as required’ medications. All medication charts had photo identification but not all charts had an allergy status identified. | (i) Ensure there is evidence of medications received, reconciled against the medication charts. (ii) Ensure a process is implemented around ensuring all medications are within expiry dates, and (iii) ensure all medication charts identify an allergy status. | (i) Ensure there is evidence of medications received, reconciled against the medication charts. (ii) Ensure a process is implemented around ensuring all medications are within expiry dates, and (iii) ensure all medication charts identify an allergy status.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | Interventions had been implemented for residents at risk of pressure injuries and falls. Food and fluid charts were in place for residents at risk of weight loss as identified in mini nutritional assessments, and behaviour charts were in place to monitor resident behaviours, however there were no documented interventions for three residents with weight loss and two residents with challenging behaviours. | (i)There were no documented interventions for three residents (two rest home and one dementia care) with unintentional weight loss and (ii) there were no documented interventions/behaviour management plan for two residents (one rest home and one hospital) as identified on the behaviour charts. These issues were being monitored and managed by staff and therefore the risk has been identified as low. | (i)-(ii) Ensure there are documented interventions to meet the resident current health status  90 days |

# 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.

|  |
| --- |
| No data to display |

End of the report.