

# Radius Residential Care Limited - Radius Matua Lifecare

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## 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 Matua

**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: 1 September 2020 End date: 2 September 2020

**Proposed changes to current services (if any):** The opening meeting identified a total of 154 beds (64 rest home beds including five identified as studio units); 68 hospital beds and 22 dementia beds. The hospital beds have already been identified as dual-purpose beds. This certification audit has verified 60 extra dual-purpose beds (including five studio units) giving a total of 128 dual-purpose beds; four rest home beds (two double rooms in the rest home area identified as rooms 11 Rimu and 9 Rata); and 22 dementia beds. Overall bed numbers remain the same.

**Total beds occupied across all premises included in the audit on the first day of the audit: 145**

# Executive summary of the audit

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## 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 Matua is owned and operated by Radius Residential Care Limited. The service provides cares for up to 154 residents requiring rest home, hospital (medical and geriatric) or dementia level care. On the day of the audit, there were 145 residents. The service is managed by a facility manager who has been in the role for six years with support from the Radius regional manager, a nurse manager, assistant facility coordinator and a team leader for each unit/area. Residents, relatives, and the GP interviewed spoke positively about the service provided.

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

This audit has not identified any areas requiring improvements.

The service has exceeded the standard around communication during the lock down period of the pandemic, and the activities programme.

## Consumer rights

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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Policies and procedures adhere with the requirements of the 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. There is an established Māori health plan in place. 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. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Examples of good practice were provided. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commission (HDC).

## Organisational management

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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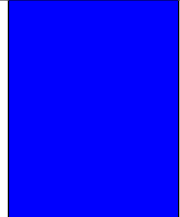
Services are planned, coordinated and are appropriate to the needs of the residents. A facility manager, assistant facility coordinator and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. Quality and risk management programmes are embedded. Corrective actions are implemented and evaluated where opportunities for improvements are identified. Falls management strategies are being implemented.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff that is specific to their role and responsibilities. Ongoing education and training programmes are in place, which include in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week. Residents and staff reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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A newly employed chef is in the role of kitchen manager with meals prepared on site. The Food Plan is current. The menu has been approved by a dietitian. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were satisfied with the food service.

Each resident has access to individual and group activities programmes. The group programme is varied and reflects input by the residents.

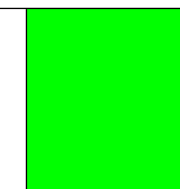
There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files included medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent senior healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The diversional therapist implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Snacks are available at all times.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and most have their own ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible, and the dementia garden is secure. Cleaning and laundry 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.

## 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 facility is restraint-free. Staff receive regular education and training on restraint minimisation and managing challenging behaviours. There was one enabler in use at the time of the 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.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidenced that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. 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. The facility has responded promptly and appropriately to the Covid pandemic, and Ministry of Health and Public Health directives.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	2	43	0	0	0	0	0
<b>Criteria</b>	2	91	0	0	0	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Radius Matua policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme.</p> <p>Interviews with staff including 13 healthcare assistants (four from the rest home, five from the hospital and four from the dementia unit), four registered nurses (one from the rest home, one from the dementia unit, and two from the hospital), one activities coordinator/diversional therapist, two activities assistants, two laundry staff and two cleaners, assistant facilities coordinator, kitchen manager (chef), maintenance manager, one team leader housekeeping, and the physiotherapist confirmed their understanding of the Code.</p> <p>Nineteen residents (14 rest home level including four in studio units, and five hospital level residents including one in a studio unit) and eight relatives (two hospital level, three rest home level and three dementia level) interviewed, confirmed that staff respect privacy, and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their enduring power of attorney (EPOA). All residents in the dementia unit have</p>

<p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>an activated EPOA. Advanced directives are signed for separately. There was evidence of discussion with family when the general practitioner completed a clinically indicated not for resuscitation order. The files in the hospital and rest home areas had an informed consent signed with this scanned into eCase.</p> <p>Healthcare assistants and registered nurses interviewed confirmed that 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. Staff working in the dementia unit also stated that they actively engaged with residents to give choice around activities of daily living.</p> <p>All thirteen resident files sampled (five from the rest home, five from the hospital and three from dementia rest home) had a signed admission agreement and consents completed.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files included information on residents' family/whānau and chosen social networks.</p> <p>The local independent advocate visits the facility at least annually to talk with residents.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>CI</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility noting that the pandemic during lockdown periods curtailed this activity.</p> <p>Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.</p> <p>The service has exceeded the standard with initiatives to engage in communication with residents and relatives during the pandemic.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available 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.</p> <p>A complaints register includes complaints received, dates and actions taken. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner</p>

		<p>(HDC). They are signed off by the facility manager when closed. There is evidence of lodged complaints being discussed in the quality and staff meetings.</p> <p>Seventeen complaints were lodged in 2019 and eleven in 2020 (year to date). Four complaints lodged in 2020 were selected for review in detail and confirmed adherence to HDC response timelines. A detailed investigation was completed for each complaint. One complaint lodged reflected input from the HDC Advocacy service as requested by the resident. Complainants are given the contact details of HDC if they are not satisfied with the outcome. All complaints in the register (2019, 2020) have been documented as resolved.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service and includes specific information about the dementia unit. There is the opportunity to discuss aspects of the Code during the admission process.</p> <p>Residents and relatives interviewed confirmed that information had been provided to them around the Code.</p> <p>Large print posters of the Code and advocacy information are displayed throughout the facility. 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>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed there are areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with HCAs described how choice is incorporated into resident cares.</p> <p>There are two double rooms in the rest home wings and three in the hospital. Only one double room in the rest home has a couple occupying the room and the others are occupied by a single resident. The couple sharing a room has agreed to share a room as part of the service agreement. There are curtain tracks in place should the couple decide that they want curtains up in the room separating beds.</p>
Standard 1.1.4: Recognition	FA	The Māori health plan policy for the organisation references local Māori health care providers regionally

<p>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>		<p>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 disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan.</p> <p>One care plan reviewed for a Māori resident confirmed that their cultural needs were assessed and the plan included specific interventions as per the assessment.</p> <p>The managers stated that they can seek advice and support with an identified person from Ngati Ranginui. There are also Māori staff who can provide input and advice if required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate, are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. A review of resident records confirmed that 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 staff (team) meetings and toolbox talks include discussions around professional boundaries and concerns noting that because of the Covid pandemic, some meetings have had to be postponed and toolbox sessions have taken their place.</p> <p>Professional boundaries are discussed with each new employee during their induction to the service. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the healthcare assistants' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there are any specific issues raised.</p> <p>A review of incidents and complaints for 2020 did not identify any evidence of discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services</p>	FA	<p>All Radius facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.</p>

<p>of an appropriate standard.</p>		<p>A range of clinical indicator data is collected for collating, monitoring, and benchmarking between facilities. Indicators include (but are not limited to) resident incidents/accidents, resident infections, staff incidents/accidents or injuries. Feedback is provided to staff via staff meetings. Corrective actions are developed where results do not meet acceptable targets.</p> <p>The Radius eCase electronic resident information (eg, care plans, monitoring charts) has been implemented that allows for less paper-based documentation. Interventions (eg, weight management, falls management strategies, pain management, neurological observations, behaviour management) are all documented using eCase.</p> <p>Annual resident/family satisfaction survey results reflect high levels of satisfaction with the services received.</p> <p>A general practitioner visits the facility two – four times a week (minimum of twelve hours) with 24/7 on-call services. Physiotherapy services are provided 21 hours a week. Two clinical pharmacists screen the medications of all new admissions. Care plans reviewed reflected input from allied health professionals.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<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. All adverse events reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member.</p> <p>There is an interpreter policy in place and contact details of interpreters were available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Radius Matua is a Radius aged care facility located in Tauranga. The facility is certified to provide rest home, hospital (medical and geriatric), and dementia levels of care for up to 154 residents. There were 145 residents living at the facility during this full certification audit: 58 residents were at rest home level of care, 67 at hospital level of care and 20 at dementia level of care. Two residents were on respite (rest home level) and the remaining residents were on the aged related care contract.</p> <p>This audit assessed the suitability of all but four (two double rooms with two beds in each) rest home beds in the rest home wings as suitable for dual-purpose use (either rest home or hospital level of care). This included five studio apartments. Overall, the audit verified 60 extra dual-purpose beds (including five studio units) giving a total of 128 dual-purpose beds.</p> <p>The 2020/2021 business plan describes the vision, values, and objectives of Radius Matua. Strategic goals under the headings of care leadership and management; finance leadership and management; risk management, business and services, and marketing and promotion are linked to the annual business plan.</p>

		<p>Goals are reviewed a minimum of three-monthly and the business plan is updated annually.</p> <p>The facility manager has been employed at Radius Matua for six years. Previously, he has held managerial positions in the health sector. The facility manager is supported by a clinical manager/RN and an assistant facility coordinator. A regional manager provides additional support and was available during the audit.</p> <p>The managers have maintained over eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The assistant facility coordinator covers the facility manager in the absence of the facility manager. Three team leaders/registered nurses (one rest home, one hospital, one dementia) cover during the absence of the clinical manager. Radius has interim (roving) facility managers and clinical managers who cover extended absences. The regional manager is a registered nurse who is available on a 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>	FA	<p>An established quality and risk management system is embedded into practice. Quality and risk performance are reported across facility meetings and to the regional manager. Discussions with the managers (regional manager, facility manager, and clinical manager/RN), and staff (assistant facility coordinator, four RNs, thirteen healthcare assistants (HCAs) who work across all three shifts, kitchen manager, maintenance manager, physiotherapist, two laundry staff, two housekeeping staff, one team leader/housekeeping, three activities staff) reflected their involvement in quality and risk management processes.</p> <p>Resident and family meetings are three-monthly with evidence of their active participation. Annual resident and relative surveys were last completed in November 2019 with 72 respondents. Approximately 82% of residents and families who participated in the survey expressed their satisfaction of the expectations of Radius Matua. The outcome of the survey and analysis report were reported at the quality meeting (14 January 2020). Only one corrective action was necessary to address concerns regarding food temperatures, which has been implemented.</p> <p>The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level by the clinical managers group, with input from facility staff every two years.</p>

		<p>Clinical guidelines are in place to assist care staff.</p> <p>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. The facility has implemented established processes to collect, analyse and evaluate data, which are utilised for service improvements. Internal audits are completed as per the audit schedule. Quality results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are implemented where results reflect opportunities for improvements. Corrective actions are signed off when implemented.</p> <p>A number of quality improvements have been implemented since the previous audit (link to CIs 1.1.12.1,1.3.7.1). In addition, an ACC pressure injury prevention programme is in the process of being rolled out.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. Two health and safety officers (assistant facility coordinator and maintenance staff) were interviewed during the audit. They are supported by two health and safety representatives. 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. All new staff and contractors undergo a health and safety orientation programme with evidence sighted of staff and contractors participating in annual health and safety refresher programmes.</p> <p>Falls prevention strategies are being implemented. The physiotherapist assesses all new residents. Re-assessments are completed six monthly and post falls. Falls prevention classes, led by the physiotherapist, are held separately for rest home (two times/week, 30-minute duration) and hospital level (once per week, 15-minute duration). Approximately eight hospital level residents who were identified as a high risk of falling between the hours of 4 pm – 7 pm are monitored in a group setting in the lounge with no evidence of further falls during this period of time. This programme was initiated in June 2020. Other interventions to reduce the risk of residents falling include (but are not limited to) intentional rounding, sensor mats, and perimeter mats.</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</p>	<p>FA</p>	<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(s) required. They are signed off by the clinical manager when completed.</p> <p>A review of 18 incident/accident reports (17 witnessed and unwitnessed falls, one pressure injury), identified that the electronic forms are fully completed and included follow-up and investigation by a registered nurse.</p>



<p>affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>Neurological observations are implemented for any suspected injury to the head and/or unwitnessed fall.</p> <p>The facility manager and regional manager are able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. Public health authorities were notified for two suspected outbreaks (April 2019, April 2020). Section 31 reports have been completed for pressure injuries and residents who have absconded and required the assistance of police.</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>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation, and staff training and development. Thirteen staff files reviewed (four RNs, six HCAs, two cleaners, one driver) included documentation to confirm a recruitment process was undertaken (interview process, reference checking, police checks). Also sighted were signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates are maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. Annual and two-yearly core compulsory topics are scheduled with staff expected to complete a written core competency for each topic (eg, code of rights, cultural safety, aging process, abuse/neglect, sexuality and intimacy, restraint minimisation, informed consent, communication, accident and incident reporting, infection control, emergency procedures, fire safety, health and safety, food handling, chemical handling, challenging behaviours, continence management). There is an attendance register for each training session and an individual staff member record of training.</p> <p>Fifteen HCAs are employed to work in the dementia unit. Five have completed their dementia qualification (unit standards 2390, 2391, 23922 and 23923). The remaining ten HCAs have been working in the unit for less than eighteen months and are in the process of completing their qualification.</p> <p>Registered nurses are supported to maintain their professional competency. Ten of twenty-four registered nurses have completed their interRAI training. Completed competencies for registered nurses include (but are not limited to) medication competencies and insulin competencies.</p> <p>Annual staff performance appraisals are undertaken.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale and reflect safe staffing levels. There are a minimum of two RNs and seven HCAs on site at any time.</p> <p>At the time of the audit, the three rest home wings (Rata, Kowhai, Rimu) had 62 residents (5 hospital level</p>

<p>from suitably qualified/skilled and/or experienced service providers.</p>		<p>and 57 rest home level). The AM shift is staffed with a clinical team leader/RN five days a week (Monday – Friday). One RN and eight HCAs (four long shift and four short shift (less than seven hours per shift)) cover the AM shift; one RN and six HCAs (four long and two short) cover the PM shift. One RN and two HCAs cover the night shift.</p> <p>The two hospital wings (Magnolia and Camelia) had 63 residents (62 hospital level and one rest home level). The AM shift is staffed with a clinical team leader/RN five days a week (Monday – Friday). An additional RN covers doctor rounds and completing interRAI reports three – four shifts per week. Two RNs and eleven HCAs (eight long, three short) cover the AM shift, two RNs and nine HCAs (five long and four short) cover the PM shift. One RN and three HCAs cover the night shift.</p> <p>The dementia wing (Lavender) had 20 residents. One RN and two HCAs cover the AM shift. An additional RN covers doctor rounds and completes interRAI reports on Tuesdays. The PM shift is staffed with three HCAs (two long and one short) and the night is staffed with two HCAs (one floating between wings).</p> <p>Staff that were working on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by the residents interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory and that the managers provide good support. Residents and families interviewed reported there are sufficient numbers of staff available.</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>	<p>FA</p>	<p>The resident files are 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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident information (hard copy and electronic) is protected from unauthorised access. Entries are legible, dated and signed by the relevant care staff or registered staff, including their designation.</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>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long and short-term admission agreements sighted were signed and dated.</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>Policy describes guidelines for death, discharge, transfer, documentation, and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the 'yellow envelope' transfer system. Communication with family is made.</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 comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses a paper-based and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs administer all medications in the hospital. RNs and medication competent HCAs administer medications in the rest home and dementia unit. Staff attend annual education and have an annual medication competency completed. All RNs are syringe driver trained by the hospice. The medication room and medication fridge temperatures are checked weekly. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on medication sheets. Twenty-six medication charts were reviewed (ten hospital, ten rest home and six dementia). Medications are reviewed at least three-monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.</p> <p>The service utilises clinical pharmacologists (Medwise) to assist with the overview of medications for residents. Their focus is on reducing adverse drug events, medication errors and improving the effectiveness of medication therapy. They work together with Matua nursing staff, the pharmacist, and the GPs.</p> <p>The clinical pharmacologists (CPs) reconcile and review medications for residents being admitted to the facility to ensure that the prescribed medications are still appropriate for residents and that the dosages are correct according to their medical history.</p> <p>The CPs also reconcile and review medications for residents returning from hospital. The CP found a returning resident who was on vitamin D when admitted to hospital did not have it transcribed to the new medication chart. Given that there was a past history of fractures and biophosphonate treatment it seemed likely this was an unintentional omission and after querying this the vitamin D was restarted.</p> <p>The CPs also screen the medications of residents who are due three-monthly reviews to ensure that their medications are still relevant. They discuss any interactions or possible side effects and assist with reducing medications that are no longer needed. A resident who had been on Loratidine 10mg BD since 2014 was</p>

		<p>changed to Loratidine PRN and was thrilled to be taking one less medication. When interviewed the GP stated that he found the pharmacist three monthly reviews extremely time saving for him.</p> <p>The CPs also review medications in the community and if these people are admitted to Matua the CPs are able to provide an up-to-date medication history to the GP and pharmacist.</p> <p>The GPs and pharmacist now consult with the CPs when implementing/making medication changes or request a review if they require advice. A resident's laboratory report showed low magnesium and low potassium. The GP consulted with the CP regarding treatment and the resident was commenced on the recommended medications.</p> <p>Positive feedback has been received from the GPs, pharmacist, nursing staff, residents, and families</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. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the kitchen manager works closely with the RNs on duty. The kitchen manager is also informed of any residents who have lost or gained weight where interventions are required.</p> <p>The kitchen staff have completed food safety training. The kitchen manager (chef) and cooks follow a rotating seasonal menu, which has been reviewed by a dietitian (May 2020). The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were satisfied with the quality and variety of food served.</p> <p>The kitchen manager has recently started introducing new initiatives to engage residents in meals. This has included a weekly breakfast that varies and is 'café' like in style. Residents interviewed stated that they had noted improvements in presentation since the new kitchen manager has been appointed.</p> <p>The Food Control Plan confirms registration with expiry of this 31 March 2021.</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</p>	<p>FA</p>	<p>The service records the reason for declining service entry to prospective residents should this occur and communicates this to prospective residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>

family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall, the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but not limited to) pain, behaviour, nutrition, and continence.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs and provide detail to guide care. Care plans are updated with acute changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the clinical pharmacologist, wound care nurse and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.  Care plans for dementia residents include management of behaviours and de-escalation techniques. Electronic behaviour monitoring charts are completed as required. The DT outlines activities that are available for dementia residents over a 24-hour period.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed.  Resident falls are reported on electronic incident forms and written in the electronic progress notes. Neurological observations are taken when there is a head 'knock' or for an unwitnessed fall.  Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.  Wound assessment, wound management and wound evaluation electronic forms are in place for all wounds. Wound monitoring occurs as planned. There are currently 43 wounds being treated. The majority of these are minor. There are currently 21 pressure injuries. Twenty are facility acquired and one is non-facility acquired. There has been GP and wound care nurse specialist input. Photos have been taken. The facility

		<p>is concerned at the high numbers and currently has a quality project around prevention and management of pressure injuries as well as staff education (link 1.2.3). The facility is currently undertaking a quality project with ACC around prevention and management of pressure injuries as well as staff education. They were concerned with the high numbers and were keen to participate in this project with ACC.</p> <p>Electronic monitoring forms are in use as applicable such as weight, vital signs, and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	CI	<p>An activities coordinator/diversional therapist is employed full time to coordinate the activities programme for all residents. She is supported by three activities coordinators who provide a separate programme for each area (rest home, hospital, and dementia) with an additional full-time activity assistant employed to begin the end of September 2020. Each resident has an individual activities assessment on admission. Based on this information, an individual activities plan is developed as part of the care plan by the registered nurses with input from the activities staff. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Significant time is dedicated to one-on-one activities. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. The residents' files sampled included activities plans within the care plans that are evaluated at least six-monthly when the care plans are evaluated. Residents in the dementia unit have plans that include activities to manage behaviours over the 24-hour period and staff provide activities when activities staff are not present. Residents and families interviewed commented positively on the activity programme.</p> <p>The service has exceeded the standard around the provision of activities to meet the needs of residents, resulting in a rating of continuous improvement.</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 plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Any changes to care are updated in the care plan. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The case conference reviews involve the RN, GP, clinical pharmacist, and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And</p>	FA	<p>Referral to other health and disability services is evident in the electronic resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, mental health services for older people and the hospice. Discussion with the registered nurse</p>

<p>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>identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</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. Safety data sheets are available.</p> <p>In February 2020, the facility had implemented a waste reduction programme with the intention of reducing waste and replacing environmentally damaging items within the facility with more user friendly environmentally sustainable products. This project has already shown some benefits for the environment.</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 has a current building warrant of fitness. The building has a number of alcoves and lounge areas in each unit. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius.</p> <p>The facility has sufficient space for residents to mobilise using mobility aids, including a mobility scooter parking/charging bay. The external area is well maintained. Residents have access to safely designed external areas that have shade. There is an interesting and secure garden for the dementia unit. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>This certification audit has verified 60 rest home beds as dual-purpose beds. These include five studio units. All rooms have a one and half door for ease of access for mobility aids and equipment. There is sufficient space in all dual-purpose rooms to allow for mobility aids, staff to support each resident and for any emergency equipment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing</p>	<p>FA</p>	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Most bedrooms have their own ensuites and some have shared ensuites. Toilets and</p>

<p>Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids including those required by hospital level care residents in the dual-purpose and hospital level rooms. Residents are encouraged to personalise their bedrooms.</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>	<p>FA</p>	<p>The communal areas include the main lounge and several smaller lounges and separate dining areas in each of the rest home, hospital, and dementia units. The communal areas are easily and safely accessible for residents.</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</p>	<p>FA</p>	<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. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is done in the on-site commercial laundry by dedicated laundry staff. Residents and relatives interviewed were satisfied with the laundry service.</p>



<p>which the service is being provided.</p>		
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>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 facility has an approved fire evacuation plan. Fire drills take place every six months. Smoke alarms, sprinkler system and exit signs are in place. Gas barbeques and torches are available in the event of a power failure. 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 residents' rooms, lounge areas, and toilets/bathrooms.</p> <p>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>	<p>FA</p>	<p>General living areas and all resident rooms are appropriately heated and ventilated. 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>	<p>FA</p>	<p>Radius Matua has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPIs. The clinical manager is the designated infection control nurse with support from the registered nurses and the quality management committee (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Radius infection control programme was last reviewed in July 2016.</p> <p>The service has managed the current Covid 19 pandemic well. There has been ongoing information to all staff around how to manage any case of Covid 19 should there be one and process put in place as per policy. This has included instructions around visiting at each level, management of staff and use of PPE. There is sufficient PPE on site to manage should this be required for an outbreak including a case of COVID for at least two weeks should this be required.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The clinical manager at Matua is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the quality management team and care staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are Radius infection control policies and procedures appropriate to 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 and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>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. The infection control nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance</p>	FA	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have generally been low. Trends are</p>

<p>with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>identified and quality initiatives are discussed at staff and quality meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. Systems are in place that are appropriate to the size and complexity of the facility</p> <p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed with the owner/manager and at staff meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There was one norovirus outbreak in April/May 2019 with documentation showing that this was well managed in conjunction with infection control specialists.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. The facility is restraint free. The restraint coordinator is the clinical manager who is supported by the previous restraint coordinator (physiotherapist). Both individuals were interviewed during the audit.</p> <p>There was one enabler (lap belt on a wheelchair) in use at the time of the audit. Evidence of signed consent by the resident for the enabler was sighted. This resident had the enabler linked to their care plan and the enabler is reviewed a minimum of three monthly.</p> <p>Staff training is in place covering restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</p>

## Specific results for criterion where corrective actions are required

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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.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.12.1 Consumers have access to visitors of their choice.	CI	Radius Matua has put in place strategies to ensure that residents and family members have opportunities to communicate with each other during the lockdown period of the pandemic and initiatives to ensure that all are kept informed of facility and practice changes resulting from Ministry of Health and Public Health directives during the pandemic. The initiatives have exceeded the required	Radius had introduced two projects at the last audit to improve communication with residents’ families. The Sparkles group was introduced in July 2015 to welcome new residents/families to enable them to feel involved in the “Lavender” (dementia unit) and to educate families regarding dementia and enable them to liaise with the community and voice concerns. The second initiative was to improve the attendance of family/whānau of choice at the residents’ forum meetings. Both initiatives have continued and improved noting that during the pandemic at level four and level three, these initiatives were suspended as family were not permitted to come into the facility.  During the Covid pandemic and lockdown periods, the managers and key staff maintained constant communication with residents and family. This included communicating through email and through newsletters which were sent out to family each workday. Communication to family included updates from the facility, around the facilities Covid status, residents’ wellbeing, activities, highlights of their day and points of interest. Once the lockdown period ended, the newsletters have continued to be sent out weekly. Staff stated that this has improved communication with family who live overseas. During the lockdown period the activities team enabled residents to link with family on “video chats” through the use of messenger, with a link set up specifically for families and friends to book

		standard.	a time to be able to speak to the residents. There were approximately 50 video chats each week. The facility has continued with this form of contact for “out of town” families and those unable to visit for whatever reason. Staff and managers increased the number of one-to-one chats so that residents were kept well informed of changes at the facility during the pandemic. Successes of the strategies put in place have been measured in the commitment to continuing the initiatives, the positive comments from family and residents and the volume of letters and emails that thanked the staff for the initiatives.
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	The activities programme was enhanced significantly during the Covid 19 lockdown. In addition, the service has introduced a selection of new activities (implemented in 2019 and 2020) that meet and exceed the needs of the residents.	<p>During the Covid lockdown, the activities staff increased the level of resident participation in activities to compensate for this stressful period. Extra time was dedicated for one-on-one support. Often arm and hand massages were added to these one-on-one visits. Activities staff reported that they filled in for roles that family previously fulfilled with examples provided (eg, shopping, reading bible). A daily schedule was implemented for video chats with family and activities staff often assisted with these chats if residents were hard of hearing or were unable to operate an iPad computer. Shopping requests for residents was another added feature during lockdown. Since lockdown has ended and the activities programme has been evaluated, these initiatives are planned to continue, and an additional full-time activities staff has been employed (effective end of September 2020).</p> <p>Other activities programmes implemented reflect activities that have given residents a sense of purpose. The activities staff initiated of the twelve acts of kindness in 2019 whereby residents were involved in twelve acts of kindness during Christmas 2019 (eg, making cupcakes for blood bank, firefighters, and St Johns ambulance, donation for SPCA, knitted blankets and hats for Plunket). This has been slightly modified and extended in 2020 with the residents currently involved in fundraising for charities of their choice (SPCA, Cancer Society, Waipuna Hospice, Plunket, and Fred Hollows). Up to sixty residents have participated in these programmes including those in the dementia unit who are involved in gardening projects. Residents interviewed commented that these charitable contributions have given them added purpose in their lives and that they wish to continue with their fundraising efforts.</p>

End of the report.