

Radius Residential Care Limited - Radius Hawthorne

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Radius Residential Care Limited

Premises audited: Radius Hawthorne

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

Dates of audit: Start date: 6 July 2021 End date: 7 July 2021

Proposed changes to current services (if any): Increase of dual-purpose beds from 10 to 15 in the hospital unit.

Total beds occupied across all premises included in the audit on the first day of the audit: 88



Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Hawthorne is part of the Radius Residential Care Group. Radius Hawthorne cares for residents requiring hospital (geriatric and medical and psychogeriatric), rest home and residential disability (physical) level care. The facility can cater for up to 94 residents across two psychogeriatric units and two hospital units. On the day of the audit there were 88 residents.

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

The facility manager has been in the role since March 2020. She is a registered nurse with many years of aged care management experience and is supported by an experienced clinical manager has been at Radius Hawthorne for 10 months and has been involved in aged care for ten years and a Radius regional manager.

This certification audit identified an improvement required around pain assessments.

There is one area of continuous improvement awarded around the sensory garden in one of the psychogeriatric units.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Radius Hawthorne 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 at Radius Hawthorne to protect residents from discrimination or harassment. There is an open disclosure and interpreter's policy that staff understand. Family/friends can visit at any time and interviews verified ongoing involvement with community activity is supported. 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.
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Services are planned, coordinated, and are appropriate to the needs of the residents. The service has support from head office that includes the compliance and risk manager. The facility manager is qualified and experienced for the role. Clinical oversight provided by the clinical manager. There is a documented quality and risk management programme with key components of the system including management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, and review of risk and monitoring of health and safety, including hazards. Quality data is discussed at facility meetings. Human resource policies are in place, including a documented rationale for determining staffing

levels and skill mixes. A roster provides sufficient and appropriate staff coverage for the effective delivery of care. An orientation and training programme is documented and implemented. Registered nursing cover is provided 24 hours a day, 7 days a week.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The service has assessment processes and residents` needs are assessed prior to entry. There is an admission pack available for residents and families/ whānau at entry. Assessments, residents care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in care. The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. There are a variety of activities that are meaningful to the residents. There are medication management policies in place that meet the legislative requirements. Staff responsible for administration of medications complete annual medication competencies and education. Medication charts have photo identification and allergy status noted. Medication charts are reviewed three-monthly by a general practitioner. All food and baking is done on site. Resident`s individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

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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Appropriate documentation including an approved evacuation plan, training including fire drills. There is an emergency management plan to guide staff in managing emergencies and disasters. Civil defence supplies are in place. There were documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current building warrant of fitness. Resident rooms are personalised, and showers are spacious. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating. Communal areas within the facility are easily accessible. The outdoor areas are safe, accessible and provide seating and shade. There is one person on duty at all times with a current first aid certificate. Housekeeping staff maintain a clean and tidy environment. Documented policies and procedures for the cleaning services are implemented with monitoring systems in place to evaluate the effectiveness of these services. The laundry is done off site.

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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler or restraint, should this be required. There were no residents using any restraints and five residents utilising enablers at the time of the audit. Staff receive education on restraint minimisation.

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.

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-19 pandemic, policies, procedures and the pandemic plan have been updated to include Covid-19. Resource information is easily accessible for registered nurses if lockdown levels change after hours. Adequate supplies of personal protective equipment were sighted during the audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	43	0	1	0	0	0
Criteria	1	91	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	There is an implemented code of rights policy and procedure. Discussions with eight healthcare assistants (HCA), including four from the psychogeriatric units and four from the hospital units, four registered nurses (RN), one diversional therapist and one activities coordinator identified their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights 'the Code'. Staff receive training about resident rights at orientation and as part of the annual in-service programme.
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	There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification, social display and consent for outings. Permissions granted are also included in the admission agreements. There is documented evidence of discussion with the enduring power of attorney (EPOA) where the general practitioner (GP) has made a medically indicated not for resuscitation status. Copies of the residents' advance directive where applicable, are on file. All four psychogeriatric files reviewed had copies of the activated EPOA on file.

<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>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, in the resident information folder 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 provides opportunities for the family/EPOA to be involved in decisions.</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>FA</p>	<p>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. There is a family communications/contact sheet in resident files where staff document when family have been contacted. The service has strong community support and engagement.</p> <p>Residents on the YPD contract are engaged in a range of diverse community activities including (but not limited to) attending a community day care centre. Discussion with residents and relatives verified they are supported and encouraged to remain involved in the community and external groups. There are a number of ways Radius Hawthorne supports ongoing access to community services, for example: RSA and community activities.</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>A complaints policy and procedure is in place. The complaints procedure is provided to residents and their family within the information pack at entry. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception. Two complaints were received in 2020 and one complaint for 2021 year to date. Discussions with residents and families confirmed that their issues are addressed, and they feel comfortable to bring up any concerns. A review of the complaints register evidence that the appropriate actions have been taken in the management and processing of these complaints.</p> <p>Two complaints via the Health and Disability Commissioner from 2018 have been closed after the last audit. All complaint responses were completed within the contractual timeframes in accordance with guidelines set forth by the Health and Disability Commissioner.</p>
<p>Standard 1.1.2: Consumer Rights During Service</p>	<p>FA</p>	<p>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.</p>

<p>Delivery</p> <p>Consumers are informed of their rights.</p>		<p>Interviews with five residents from the hospital; two rest home and three hospital care, including three on young persons with disabilities contracts (YPD) and six relatives; one hospital, one rest home and four from the psychogeriatric units confirmed service is provided in line with the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. 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.</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>	<p>FA</p>	<p>A tour of the premises confirmed there were 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. There have not been any incidents related to abuse or neglect since the last audit. Residents and relatives interviewed confirmed that staff treat residents with respect. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with HCAs described how choice is incorporated into resident cares.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There is a specific Māori Health care plan and a culturally safe care policy. Discussions with staff confirmed an understanding of the different cultural needs of residents and their whānau. There is a section in the assessment tool and care plan that includes spirituality, religion and culture, psycho-social needs and family and significant others. In addition, there is a Māori care plan available if the individual resident wishes. At the time of the audit there were five residents living at the facility who identified as Māori. Two resident files were reviewed and included Maori cultures and preferences. The service has links with local Māori iwi (Ngai Tahu) for advice and support as 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</p>	<p>FA</p>	<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. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed stated that staff consider their values and beliefs.</p>

values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There 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 informed they were not exposed to exploitation. A staff employment handbook and orientation package includes a code of behaviour. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Interviews with staff informed an understanding of professional boundaries. Healthcare assistants are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with HCAs from the psychogeriatric unit could describe how they build a supportive relationship with each resident. Interviews with families from the psychogeriatric unit confirmed the staff assist to relieve anxiety.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Services are provided at Radius Hawthorne that adhere to the Health & Disability Services Standards (2008) and that 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 good practice policy supports staff in ensuring good practice is intrinsic to care delivery. The quality programme is designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility.</p> <p>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 are implemented competencies including restraint, manual handling, hand hygiene, medication management and syringe driver (for RNs). There are clear ethical and professional standards and boundaries within job descriptions.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Policies and procedures are in place to guide staff on the process around open disclosure. The facility manager and clinical manager confirmed family are kept informed. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. The most recent family/resident survey achieved 97% for communication. Bi-monthly resident and family meetings encourage open discussion around the services provided (meeting minutes sighted). A sample of fifteen incident reports reviewed for May 2021 all evidenced recording of family notification. Relatives interviewed confirmed they are notified of any changes in their family member's health status. Management and staff interviewed were able to identify the processes that are in place to support family being kept informed. The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to</p>

		visit.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Hawthorne is part of the Radius Residential Care group. The facility is certified to provide hospital, rest home, psychogeriatric and residential physical disability care for up to 94 residents, including 47 in the two psychogeriatric units and 47 in the two hospital units, including 15 dual purpose beds. Notification for the increase of dual-purpose beds from 10 to 15 in the hospital units was applied to the Ministry of Health at the time of the audit.</p> <p>At the time of the audit there were 88 residents living at the facility, 29 at hospital level, including seven residents on younger persons with disabilities contracts (one YPD resident was on respite care), three long-term chronic health conditions (LTS-CHC) contracts, two on end-of-life contracts, one on respite and one on an ACC funded contract. There were 14 at rest home level, including two on LTS-CHC contracts and 45 at psychogeriatric level.</p> <p>There is a site-specific business plan 1 April 2021 to 31 March 2022 that has been reviewed and links to the Radius Residential Care group strategies and business plan targets. An organisational chart is in place. Monthly reviews are undertaken to report on achievements towards meeting business goals including meeting defined quality targets.</p> <p>The facility manager is a RN with many years of aged care management experience and has been in the role since March 2020. Prior to commencing at Radius Hawthorne she had been in a similar management role with Radius for three years. The clinical manager has been at Radius Hawthorne for 10 months and has been involved in aged care for ten years including three years as a clinical manager. She is supported by a clinical team leader.</p> <p>The facility manager and clinical manager maintained at least 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</p>	FA	<p>The clinical manager covers during the temporary absence of the facility manager. The regional manager is available for support. Radius also has roving facility and clinical managers who can provide support during absences.</p>

services to consumers.		
<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 is reported across facility meetings and to the regional manager. Discussions with the facility manager, clinical manager and staff reflected staff involvement in quality and risk management processes. The quality monitoring programme is designed to monitor contractual, standards compliance and service delivery. There are clear guidelines and templates for reporting. Quality results are communicated to staff across a range of meetings (monthly head of department, quality/health and safety, staff and RN meetings) and reflect actions being implemented and signed off when completed. Resident meetings are scheduled bi-monthly are led by the facility manager. Minutes are maintained.</p> <p>The service has policies and procedures and associated implementation systems to provide an appropriate 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 facility has implemented established processes to collect, analyse and evaluate data (e.g., falls, infections, restraint use, physical aggression, medication errors, unintentional weight loss) which are utilised for service improvements. An internal audit programme is implemented. Internal audits are completed as per the schedule. Corrective actions are required for results that reflect less than 95% compliance. The audit is then repeated after eight weeks. A corrective action plan register is being implemented. Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>The resident/relative satisfaction survey for 2021 (97%) reported a 29% overall satisfaction increase from the 2020 resident/relative satisfaction survey (68%). A food satisfaction survey was also completed in May 2021. Results were discussed with residents in the resident meeting. Corrective actions being implemented for the surveys include spiritual and cultural support in the psychogeriatric units and larger resident meal sizes. Interviews with residents confirmed that they are pleased with the actions taken. Health and safety policies are established by head office. The health and safety officer (maintenance person) interviewed confirmed his understanding of health and safety processes. The maintenance person has completed external Safety & Action training to work safe standards. Risk management, hazard control and emergency policies and procedures are in place. There is a current hazard register which was last reviewed in February 2021.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by</p>	FA	<p>There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the clinical manager and analysis of incident trends occurs. Incidents are included in the Radius key performance indicators (KPIs). There is a discussion of incidents/accidents at monthly staff meetings including trends and actions to minimise recurrence. Clinical follow up of residents is conducted by a RN as confirmed in the 15 incident reports sampled. Discussions with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Three section</p>

<p>the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>31 incident notifications have been completed since the last audit. The notifications related to three resident's aggressive behaviour in the psychogeriatric units. A norovirus outbreak in January 2020 was notified to the public health authorities.</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>There are human resource management policies in place which includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Ten staff files were reviewed (one clinical manager, one clinical team leader, two RN's, four HCAs, one diversional therapist and the maintenance person) evidenced that reference checks were completed before employment was offered. Annual staff appraisals were evident in eight staff files reviewed with the other two staff members new to the service. A register of registered nursing staff and other health practitioner practising certificates is maintained. Competencies are completed for restraint, manual handling, hand hygiene, medication management and syringe driver. Completed orientation is on files and staff described the orientation programme. The service has an orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>An annual in-service programme is provided with all compulsory block training sessions provided annually. Compulsory topics include 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 are 56 HCAs in total, 29 have completed level four, 10 have completed level three and one has completed level two. There are currently 20 RNs in total and 10 of them are interRAI trained. There are 27 HCAs who work across the two psychogeriatric units. Sixteen have completed the dementia NZQA standards. Five HCAs are in the process of completing their dementia standards and there are six that have not completed their dementia standards, all commenced work with the last 18 months and have been enrolled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A Radius policy is in place for determining staffing levels and skills mix for safe service delivery. Sufficient staff are rostered on to manage the care requirements of the residents. The facility manager and clinical manager both work full-time and jointly cover on-call responsibilities. Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations within contractual timeframes. Interviews with residents and family members identify that staffing is adequate to meet the needs of residents.</p> <p>The service is divided into four units with staffing as follows:</p> <p>Brunner (psychogeriatric unit): currently 18 of 20 residents. There is an RN on duty 24 hours per day. The</p>

		<p>RNs are supported on the morning and afternoon shifts by four HCAs two on full shifts and two on short shifts. On the night shift, there is one HCA.</p> <p>Victoria (psychogeriatric unit): currently 27 of 27 residents. There is an RN on duty 24 hours per day. The RNs are supported on the morning and afternoon shifts by five HCAs two on full shifts and three on short shifts. On the night shift, there is one HCA.</p> <p>A qualified diversional therapist and two activities staff provide a programme weekdays and care staff provide activities in the psychogeriatric units during the weekend.</p> <p>Sumner (hospital/rest home unit): currently 25 of 27 residents (2 rest home and 23 hospital). There is an RN on duty on the morning and afternoon shifts. The RNs are supported on the morning and afternoon shifts by four HCAs two on full shifts and two on short shifts. On the night shift, there is one HCA.</p> <p>Wanaka/Tekapo (hospital/rest home unit): currently 18 of 20 residents (12 rest home and six hospital). There is an RN on duty on the morning and afternoon shifts. The RNs are supported on the morning and afternoon shifts by three HCAs two on full shifts and one on short shift. On the night shift, there is one HCA.</p> <p>Sumner and Wanaka/Tekapo units share the RN on the night shift. The Sumner and Wanaka/Tekapo units are adjacent to each other.</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 were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are held in an electronic format and are protected from unauthorised access.</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 pre-entry and admission procedures in place. All resident files evidenced approval for the level of care by the need's assessment coordinators. The clinical manager liaises closely with the assessing teams to ensure the service can meet the assessed resident needs. The service has a well-presented information booklet for residents/families at entry. Information includes family support programmes and contact details for advocacy to support and younger people with physical disabilities.</p> <p>Six family members interviewed stated they received sufficient information on the services provided and were appreciative of the staff support during the admission process. Admission agreements had been signed within a timely manner. Ten admission agreements reviewed align with all contractual requirements.</p>

		Exclusions from the service are included in the admission agreement. Four resident files reviewed from the psychogeriatric unit had activation letters for enduring power of attorney integrated within their file.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The transfer /discharge/exit procedures include a transfer/discharge form, and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident. Hospital discharge documentation is integrated in the resident file and care plan.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. The controlled drug register evidence a process of reconciliation of controlled drug stock. All medicines are stored securely. Registered nurses and HCAs complete annual medication competencies and medication education. The medication room is near one of the nurse's station. RNs complete the administration of medication; there are four lockable medication trolleys. A recent medication management internal audit was completed with no corrective actions or medication errors/ incidents. The RNs are responsible for medication reconciliation against the medication packs for regular and 'as required' medications.</p> <p>Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. The medication fridge temperature and medication room temperature are being monitored daily and both were within acceptable limits. There are procedures in place to facilitate safe self-administration of medication for two residents (inhalers). There are no medication standing orders in use. All eye drops were dated on opening. Twenty electronic medication charts were reviewed (including eight from the psychogeriatric unit). All medication charts had photo identification and an allergy status. The GP reviewed the medication charts at least three-monthly. Prescribed 'as required' medications included the indication for use and the effectiveness was recorded in the progress notes. Nutritional supplements are documented and administered from the medication chart.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this	FA	There is a large commercial kitchen, and all food is cooked on-site. The food service is contracted out to Cibus Catering limited. There is a comprehensive kitchen manual in place. There are a kitchen manager (qualified chef) and supported by a weekend chef. They are supported by three kitchenhands. There is a seasonal menu in place. The company dietitian has reviewed the menu. The service has a verified food control plan that expires in August 2021. The cook receives a dietary profile for each resident with dietary requirements, special diets, food allergies, likes and dislikes.

<p>service is a component of service delivery.</p>		<p>The kitchen manager interviewed is knowledgeable regarding specific residents needs including those with diabetes, unintentional weight loss (or gain) and recent dietitian input. Alternatives are offered. The cook is notified of any dietary changes for the residents. Food is plated in the kitchen and transported in hotboxes to the dining rooms. The workflow and space in the kitchen are adequate and promote efficiency. There are three dining areas are large enough for residents, mobility equipment and individual wheelchairs. Special diets are plated and labelled. The fridge and freezer have visual temperatures, which are recorded daily on an electronic catering software system. The facility fridges temperatures are monitored (records sighted).</p> <p>Temperature of food on delivery is recorded. The late afternoon meal was observed in the Victoria dining room. The staff assisting residents with their meals promoted and encouraged dining room ambience. There were enough staff to assist with meals in a timely manner and specialised cutlery was available. Residents that may eat slower, food were kept in the hotboxes to maintain the ideal state and temperature of the food before it was served. Feedback on the service and meals is by direct verbal feedback, as an agenda item at residents and family meetings. Residents and relatives interviewed were satisfied with the food choices and meals provided. Staff working in the kitchen have food handling certificates and receive ongoing training.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or if there are no beds available. Management communicates directly with the referring agencies and family/whanau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The RNs completes an initial assessment on admission including risk assessment tools as appropriate. An interRAI assessment is undertaken within 21 days of admission and every six months. Resident needs, support and goals are identified through the on-going assessment process and form the basis of the long-term care plan. There were regular pain assessments evident for a resident with complex co- morbidities, however the resident on hospital respite care did not have a timely pain assessment completed (Link 1.3.3.3). Residents interviewed confirmed their preferences and choices are accommodated during their care journey. The information gathered at admission such as allied health notes, needs assessment, discharge summaries and discussion with the EPOA and the resident, is used to develop care needs and support to provide best care for the residents.</p> <p>An initial assessment covers all activities of daily living and specific assessment tools are used for behaviour,</p>

		<p>falls risk, nutritional risk, pain assessment and communication tool. The physiotherapist completes an initial mobility assessment for all residents on admission and reviews residents post falls and at least six-monthly. The falls risk assessment tool is repeated for any resident with three falls or more in a month. YPD residents' long-term mobility, seating and postural support needs are assessed with the resident (where able) and their family/ whanau.</p> <p>The initial `about me` and `leisure assessment` include details around community involvement, cultural and spiritual needs. The diversional therapist and other activities staff complete a comprehensive social assessment in consultation with the resident/family. Resident files reviewed included an individual assessment that includes identifying diversional, motivation and recreational requirements to maintain community involvement and engagement, according to the resident's preference and choice (Link 1.3.3.3). Behaviour assessments, spiritual and cultural needs had been completed in consultation with the resident and relatives. All four files reviewed of residents in the psychogeriatric unit had a completed activities assessment, 24-hour diversional therapy plan and behaviour assessments chart completed within the stated timeframes.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans are developed in consultation with the resident, family, activity staff, diversional therapist and other allied health input (including discharge notes, GP instructions, community interRAI assessments). InterRAI assessment triggers and scores forms the basis of the long-term care plan. Care interventions are detailed to a level that supports their individual needs and goals. Assessment outcomes were included in the long-term care plans reviewed. The long-term care plan identifies interventions that cover a set of goals including managing medical needs/risks. Alerts on the resident's profile page identify current and acute needs such as (but not limited to); allergies, advance directives, current infection, wound or falls risk. Short-term needs are added to the long-term care plan. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process.</p> <p>Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration. One resident (hospital) had a specific plan for unintentional weight loss. Communication needs are documented for those residents with speech impairments. Staff interviewed are knowledgeable about all individuals in their care and the care approaches they require. Care staff confirmed they have received education in effective communication to effectively care for those residents with speech deficits. Staff were also observed in the dining room interacting with the residents in a respectful manner. Short term care plans are utilised for short term needs including weight loss, wound care, infections and eye care.</p> <p>All files include a 24-hour activity plan and recreational plan with documented individual daily routine. For those residents that present with challenging behaviours; triggers, and activities to distract and de-escalate behaviours are documented with associated risks. There was evidence of allied health care professionals</p>

		involved in the care of residents including physiotherapist, podiatrist, dietitian, specialist dementia services and an occupational therapist. The contracted physiotherapist review residents for mobility support and seating requirements and will refer if required. The GP, dietitian and allied health professional progress notes were evident in the resident's files sampled. Progress notes document family involvement. Any change in care required is documented and verbally passed on to relevant staff.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observation and interview with the RNs verified that care provided to the residents is consistent with their needs, goals and plan of care. The interview with the GP confirmed that discussion and referral to allied health professionals took place in a timely manner. When medical input was required, notification occurred promptly, and any medical orders were appropriately carried out. Family/whānau expressed during interview that assistance was given according to the wishes of their relatives. Specialised equipment including sensor mats, hoists (standing and full), transfer belts, lap belts, pressure relieving mattresses and cushions were available for use. There is a process where equipment (including individualised equipment used by the YPD residents) is checked for safety and maintained by the appropriate services.</p> <p>The service procured recently new equipment including oxygen concentrators, recliner chairs, standing hoist, bariatric hoists and new slings. Continence, wound care products and PPE were in stock for use. Staff received annually education in continence management and wound care management. The wound register was reviewed and current; an updated wound care policy including PI management, and management of skin, nutrition and hydration needs were reviewed. Wound assessment and wound management plans were in place for twenty wounds (across services). There were thirteen minor skin tears, one pressure injury (unstageable) one ulcer, one surgical wound and four other skin conditions documented and unresolved in the wound register. Wound assessments, plans and reviews are current and completed.</p> <p>Dressings were undertaken in the stated timeframes. History of internal audits around completion of wound documentation evidence Radius Hawthorne identified gaps when completing wound charts and were actively working on improvement of wound management plans. Registered nurses interviewed were aware of when and how to get specialist wound advice when needed. Monitoring records for (but not limited to) weight, catheter changes, peg changes, food and fluids, blood sugars, behaviours and routine observations including neurological observations after unwitnessed falls evidence that service demonstrates that appropriate care delivering are occurring. Monitoring forms are completed in the stated frequency.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of</p>	CI	<p>The diversional therapist works Monday to Fridays (8.30am-4.30pm) a week and is supported by two activities coordinators (9.30am-4.30 one working Tuesdays to Thursdays and the other one works Tuesdays to Fridays). All are responsible for documentation completion and spends one on one time with residents.</p>

<p>the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>One activities coordinator focusses on exercises and mobility and works closely with the physiotherapist (Tuesdays 1pm-4.30pm). Care plans acknowledge spiritual and culture needs. There is an integrated rest home/hospital and separate programme for the psychogeriatric unit scheduled across six days. Activities are provided between 9am- 4.30 pm Monday to Saturdays. There is music therapy on a Monday in the psychogeriatric unit and combined group activities with rest home and hospital residents from Tuesdays to Fridays. There is an activities person that will assist with activities on Sundays (9.30am-3.30pm) in the psychogeriatric unit. There are two regular volunteers that assist with various activities. Residents are accompanied to community involvement activities. The activities staff have one-on-one time with residents who are unable or who choose not to participate in the programme. The younger people with disabilities are supported to maintain community links .</p> <p>The activities staff at Radius Hawthorne provide an activities programme encompassing links to the restorative model of care and enabling strong community links for the residents. The diverse cultures within the facility are incorporated within the programme. A monthly activities calendar is distributed to residents and is posted on noticeboards. Group activities are voluntary and developed by the activities staff in consultation with the residents (including YPD), HCAs and RNs Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities and is age appropriate. A number of clubs and groups have been initiated by residents including the younger people. Activities are purposeful and focussed to decrease depression, challenging behaviour and mindfulness (word puzzles, memory group, memory boxes). There is evidence of pastoral care though the provision of church services. Activities for younger people are documented to the extent clinically appropriate do reflect the resident’s former routines and community engagement including Maori community links, cultural and spiritual needs.</p> <p>Activities included ` a taste of Maori culture with a hangi on Waitangi Day`. On the day of the audit residents were involved in gym activities in the gym. The activities coordinator interviewed express that the gym is available as one to one activity and under supervision. This seems to be extremely popular and email feedback from resident families expressed appreciation was sighted. There was evidence of engagement with artistic activities. Special interest groups include a creativity group and art group. Younger people are supported to access community groups/events of their interest including but not limited to RSA. The activity staff completes an initial assessment and resident profile, an activity care plan, and a 24-hour activities plan (link1.3.3.3). Evaluations are completed six-monthly as part of the multidisciplinary team review and complex team meetings. Activities are varied to meet the needs of the groups of residents at the service. The service has a van which is used for resident outings and trips into the community. Residents and relatives interviewed spoke positively of the activity programme with feedback and suggestions for activities made in resident meetings. Residents were observed watching a kapa- haka entertainment group in the morning and participating in baking later in the day.</p>
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<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The initial care plan is evaluated in consultation with the resident/ relative and long-term care plans developed. Long-term care plans reviewed had been evaluated six monthly or earlier for any changes to health. The resident/relative are invited to attend the multidisciplinary review (case conference review) with the clinical manager, RN, HCAs and DT. There is a written evaluation against the resident goals that identifies progression towards meeting goals. Long-term care plans are updated with any changes to meet the resident goals. Short-term care plans were evident for the care and treatment of short-term problems for residents, and these had been evaluated, closed or transferred to the long-term care plan if the problem was ongoing.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Radius Hawthorne access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. There was evidence of referrals to the dietitian, specialist dementia nurse, occupational therapist, wound care specialist, continence advisor, ear health nurse, physiotherapy and the podiatrist.</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>The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents and forms are completed by staff. There are no incident/accident reports reviewed involving waste, infectious material, body substances or hazardous substances. There is an emergency plan to respond to significant waste or hazardous substance management.</p> <p>All chemicals sighted were appropriately stored in locked areas. Chemicals supplied are appropriately labelled. Sufficient gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. The current systems for managing waste and hazardous substances is satisfactory.</p>
<p>Standard 1.4.2: Facility Specifications</p>	<p>FA</p>	<p>The building holds a current warrant of fitness, which expires in January 2022. Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted by an external fire safety contractor. When an issue requiring maintenance is noticed the maintenance person deals with the</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>issue on the same day. In most cases the issue can be repaired or resolved on the same day. The maintenance person is available from Monday to Friday. External contractors are engaged to complete work as required. A sample of hot water temperatures are taken monthly, and these are maintained at (or just below) 45 degrees. When temperatures were observed to be outside acceptable range, corrective actions were initiated and corrected.</p> <p>The facility's amenities, fixtures, equipment and furniture are appropriate for the level of service contracted. There is sufficient space to allow residents to move around the facility freely. The hallways have handrails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Residents' bedrooms throughout the facility have resident's own personal belongings displayed. External areas and garden areas surrounding the facility are well maintained. Level paths to the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained. The two psychogeriatric units are secure, and each has an attractive secure garden.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are an adequate number of toilets and showers in each unit. Each bathroom has a hand basin and communal toilets have hand washing and drying facilities. There are soap dispensers in all bathrooms. There are separate staff/visitors' toilets. There is signage to promote effective hand washing techniques in the staff and visitors' toilet. There are alcohol pumps available throughout the facility. The facility has a specially designed bathroom suited for bath trolley use. The facility was clean, well presented and odour free. The Sumner unit has full ensuite facilities and are satisfactory to meet the needs of the residents.</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</p>	<p>FA</p>	<p>There is adequate space in all bedrooms for residents and staff. Healthcare assistants confirmed they could move freely to provide cares and there is enough space to move mobility equipment safely. Doorways into residents' rooms and communal areas are wide enough for wheelchair, power wheelchairs, trolley and bed access. Residents interviewed stated they are happy with their rooms.</p>

group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has a main lounge and dining area in each unit. There are smaller lounge areas within the facility. Residents were seen to be moving freely throughout the facility. Residents can move freely from their bedrooms to communal rooms and the outside. Internal and external doorways are level with pavements, which allows wheelchair access. Activities occur in the main lounges and residents can access their rooms for privacy when required. Residents stated that they are happy with the layout of the hospital. There are large sunny lounges , spacious dining room areas and outdoor access and this is satisfactory to meet the needs of all resident groups.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are cleaning policies and processes. Cleaning audits occurred regularly for compliance. There are sluice rooms in each unit for the disposal of soiled water or waste. On the day of the audit, these were locked when unattended. The cleaners' rooms are designated areas and clearly labelled. All laundry is done off-site.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an emergency management plan to guide staff in managing emergencies and disasters. The NZ Fire Service approved the evacuation scheme on 31 August 2010. There is a minimum of one first aid trained staff member on every shift. The facility has an approved fire evacuation plan. Fire evacuation drills take place every six months with the last drill occurring on 3 February 2021. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and at the compulsory block training session.</p> <p>There is civil defence wheelie bin available that is reviewed bi-monthly. There is sufficient water stored (10,000 litres) in the ceiling space for three litres per day for three days per resident with additional bottled water stored in the maintenance shed. There are alternative cooking facilities available with three gas BBQs and gas Hobbs in the kitchen. Electronic call bells were evident in resident's rooms, lounge areas and toilets/bathrooms. Call bells are checked monthly. The facility is locked before nightfall with alarms on all access doors. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign-in when visiting the facility.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. The facility has thermostatically controlled wall mounted heaters in each resident room and heat pumps in communal areas. All bedrooms and communal areas have at least one external window. The indoor temperatures were pleasant and warm.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The Infection Control (IC) programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse has been in the role twelve months (and as a RN for over two years) and has a job description outlining the responsibilities of the role. She is supported by an infection control committee, clinical manager and the Radius Infection Control Advisor at head office. The infection control programme is discussed monthly and discussed at RN, team, quality and health and Safety committee meetings. The IC programme is annually reviewed at an organisational level.</p> <p>There is a Covid-19 prepared plan according to risk levels. Visitors are asked not to visit if unwell. There is QR screening and declarations in place for all visitors, staff and contractors. Hand hygiene notices are in use around the facility and there are hand sanitizers strategically placed throughout the building. Relatives have been kept updated on visiting policies during Covid lockdown and outbreak lockdown by phone calls, emails and face book notices. Residents and staff had been vaccinated against Covid-19. Each resident had a short-term care plan to guide staff in reporting any adverse effects.</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 monthly infection control committee meeting includes representatives from across the services. The committee meet monthly, and data is discussed and published in the monthly minutes and graphs that are available to all staff. The infection control nurse has completed Covid-19 online learning and formal infection prevention and control learning. The service also has access to an infection control and prevention team at the DHB, Public Health, GPs and local community laboratory infection-control team.</p>
<p>Standard 3.3: Policies and</p>	FA	<p>There is an infection control manual, which includes policies and procedures appropriate for the size and complexity of the service. Policies are reviewed at head office in consultation with all infection control nurses.</p>

<p>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>		<p>Any changes or updates to the infection control policies are notified at staff meetings and are recorded in the staff meeting minutes. There is a Radius Covid-19 policy and outbreak management plan in place.</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>	<p>FA</p>	<p>The infection control nurse is responsible for coordinating/providing education and training to staff. All staff receive infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control hand-hygiene competency annually. There has been additional Covid training including weekly meetings, the correct use of personal protective equipment and donning and doffing competencies. There is an infection control focus every month which includes in-service.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in Radius Hawthorne infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Care plans for the management of infections are added to the long-term care plan. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner.</p> <p>The infection control nurse interviewed reports the service works actively on reducing the high rate of urine tract infection at the time of the audit. Reports are easily accessible to the management team and head office staff. A confirmed norovirus outbreak in January 2020 that affected seven residents and one staff was of short duration, contained to one unit (Tekapo), managed appropriately and reported to the local public health authority.</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>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 the RNs constitute a restraint group at the facility where restraint is reviewed. There are five hospital level residents with enablers in the form of bed-sides and lap belts. No restraints are used. Review of files for residents with enablers and interviews with two residents confirmed that enabler use is voluntary and the least restrictive option possible.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	The initial `about me` and `leisure assessment` include details around community involvement, cultural and spiritual needs. Radius documentation policy (June 2019) stated `the` about me`, leisure assessment toileting, mobility, hygiene, communication, swallowing, smoking, sensory assessments need to be completed three to ten days post admission if applicable or when change in health care needs occur.	One YPD respite resident activities assessments were completed more than three weeks after admission and one hospital respite resident complained of pain and was seen by the GP, however no pain assessment was completed since admission.	<p>Ensure assessments for respite care residents are completed in a timely manner.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful, age appropriate, varied and reflect ordinary patterns of life. The programme allows residents to maintain strengths and skills, maintain connections with the community. The programme creates a sense of belonging through events and activities that they would normally not be able to access. Through various initiatives, inclusiveness, participation and a sense of belonging of residents across the service has improved. Furthermore, overall resident/relative survey results have improved from 2020 to 2021. The initiatives had a positive outcome for residents and relatives alike and will continue to be part of Radius Hawthorne’s daily practices and activities programme.</p>	<p>Following the relative/resident survey results in 2020, the facility wanted to improve on the services/activities provided to residents in their care. The following initiatives were implemented :</p> <p>1.The comments from the survey also emphasised the importance of well-maintained gardens for the resident groups at Radius Hawthorne. As a result of the feedback a sensory garden was created within one of the secure outdoor spaces of the psychogeriatric unit. The layout of the garden including a bright yellow path and bright colours (red and blue outdoor furniture) to ensure residents can easily navigate safely. The colours, shape, size, texture and patterns of the plants stimulate the senses (smell, taste and feel) and include herbs to taste and windchimes (hear). The sensory garden featured in ` The Gardener ` magazine and several emails from resident families (sighted) commented on what difference the garden made on the</p>

			<p>wellbeing of their relative in the psychogeriatric unit.</p> <p>2. The diversional therapist and activities coordinators wanted to add reminiscing activities that HCAs can provide to residents in the psychogeriatric unit or for those that prefer not to attend group activities. These activities do not need supervision. The team created memory boxes which include a) men's memory box with plastic tools and quiz cards; b) garden memory box includes garden hose connectors, flowers and herbs; c) a cat memory box including quiz cards and a lifelike cat; d) sewing memory box including yarn, material and big buttons, and e) a personalised memory box that can be personalised to the individual's needs.</p> <p>The facility manager, activity staff, HCAs and RNs interviewed confirm the above initiatives helped the residents to enhance their sense of wellbeing and to reduce anxiety. The overall satisfaction with the facilities for the specific group improved from 72% in 2020 to 100% in 2021 and from 74% satisfaction with the grounds in 2020 to 95% satisfaction. Overall care satisfaction has improved from 79% in 2020 to 100% in 2021.</p> <p>3. The facility manager wanted to improve on communication to the residents and families following a 74% satisfaction rate around communication in the 2020 survey. Following the overwhelming positive feedback received from residents and families about the communication methods during Covid- 19 period, the facility manager continued the routine communication through general social media posts and email communication. Family meeting times had changed to meet the needs of those relatives working during the day and are conducted after 5 pm. There is also a quality newsletter each month with staff news, important dates and messages. Emails (sighted) from five relatives evidence an overall appreciation for the improved communication efforts. The communication rating improved in the 2021 survey to 97%.</p>
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End of the report.