# Radius Residential Care Limited - Radius Waipuna

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Radius Residential Care Limited

**Premises audited:** Radius Waipuna

**Services audited:** 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: 27 June 2016 End date: 28 June 2016

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

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

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Radius Waipuna is owned and operated by Radius Residential Care Limited. The service provides care for up to 54 residents requiring rest home, hospital or residential disability level care. On the day of the audit, there were 48 residents. A registered nurse, with experience in aged care management manages the service. A Radius regional manager and a clinical manager support her. Residents and relatives 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 resident’s and staff files, observations and interviews with residents, relatives, staff and management.

The service has exceeded the standard around use of the art therapy programme, pressure injury management, infection control practices, procedures following the death of a resident and embedding of an improved organisational culture.

This audit has identified an area for improvement around InterRAI assessments due to difficulty in accessing training for sufficient registered nurses.

## 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

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.

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.

## Organisational management

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

Services are planned, coordinated, and are appropriate to the needs of the residents. A facility manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families report 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. |

Primarily the facility manger and clinical manager manage entry to the service. There is comprehensive service information available. A registered nurse completes initial assessments. The registered nurses complete care plans and evaluations within the required timeframe. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process.

Each resident has access to individual, group and small group activity programmes that meets the recreational needs of the residents.

Medication is managed in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Medications are stored, prescribed and administered in line with appropriate guidelines and regulations. General practitioners review residents at least three monthly or more frequently if needed.

Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

## Safe and appropriate environment

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

The building has a current warrant of fitness and emergency evacuation plan. There is an approved evacuation scheme and emergency supplies for at least three days. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy. There are an adequate number of communal showers and toilets. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are lounge and dining areas in the two wings of the facility. The internal areas are able to be ventilated and heated. The outdoor areas provide seating and shade. The internal courtyard is currently being landscaped. Cleaning and maintenance staff are providing appropriate services.

## 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. |

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The restraint coordinator maintains a register. During the audit, three residents were using restraints and two residents were using enablers. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

## 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

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 evidences 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. There have been no outbreaks since the previous 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** | 5 | 44 | 1 | 0 | 0 | 0 | 0 |
| **Criteria** | 5 | 95 | 1 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Radius Waipuna policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers’ Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with care staff (nine healthcare assistants [HCA’s], two registered nurses, the activities coordinator and the physiotherapist) confirmed their understanding of the Code. Eight residents (two rest home level, three hospital level and three young persons with disability) and five relatives (two hospital level, three residential disability level) interviewed confirmed that staff respect privacy, and support residents in making choices. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives.  Eight of eight resident files sampled, including one from the rest home, four from the hospital including one resident under a long term chronic health condition and one resident under ACC funding, two residents for residential disability (physical) and one resident for residential disability (intellectual), had a signed admission agreement and consents. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents 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 include information on residents’ family/whānau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Residents on the Young Persons with Disability (YPD) contract are engaged in a range of diverse community activities including (but not limited to) attending a community day care centre and regular visits to the local swimming pool. Relatives and friends are encouraged to be involved with the service and care. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.  A complaints register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in manager and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | CI | 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. An annual resident satisfaction survey was completed in July 2015 and the results showed that the vast majority of respondents reported overall resident experience as being good or very good. 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 residents confirmed their values and beliefs were considered. Interviews with HCAs described how choice is incorporated into resident cares.  The service has exceeded the standard around changes to processes following the death of a resident. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The Māori health plan for the organisation references local Māori healthcare providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | An initial care-planning meeting is carried out where the resident and/or whānau as appropriate 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 confirmed that staff take into account their values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | CI | Policies and procedures align with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.  An annual in-service training programme is implemented as per the training plan with training for registered nurses from the DHB and involvement in the ACE programme for all HCAs. Residents’ falls are analysed in detail. Feedback is provided to staff via the various meetings.  There is a minimum of one registered nurse on each shift and residents and family describe HCAs as being caring and competent. A number of process improvements have been implemented resulting in improvements to resident wellbeing and the service has exceeded the required standard around minimising tissue damage from pressure injuries. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | 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 nine adverse events reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member.  There is an interpreter policy in place and contact details of interpreters were available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | CI | Radius Waipuna is a Radius aged care facility located in East Auckland. The facility is certified to provide rest home, hospital and residential physical disability care for up to 54 residents. All beds are dual-purpose. A building project was nearing completion at the time of the audit. On the day of the audit there were six rest home residents (all under the aged related care contract) and 42 residents receiving hospital level care, 13 of who were on young persons with disability contracts (one with an intellectual disability and 12 with physical disabilities), five on long term chronic conditions contracts and two funded by ACC. There were no residents receiving residential disability (sensory) level of care.  The 2016 to 2019 business plan describes the vision, values and objectives of Radius Waipuna. Annual goals are linked to the business plan and reflect regular reviews via regular meetings and monthly reports to the regional manager. The service has exceeded the required standard around developing a vision that has improved resident satisfaction.  The facility manager is a registered nurse with many years’ experience in aged care management. She has been in the role since July 2014 and is supported by a clinical manager and the Radius regional manager.  The facility manager has maintained at least eight hours of professional development activities related to managing an aged care facility. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The clinical manager/RN covers during the temporary absence of the facility manager. The regional manager or facility managers of other Radius facilities are also available. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | 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 managers reflected staff involvement in quality and risk management processes.  Resident meetings are monthly. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. Survey results reflect increasing satisfaction (link 1.2.1.1).  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 clinical managers group with input from facility staff reviews the service’s policies at a national level every two years. Clinical guidelines are in place to assist care staff. Updates to policies included procedures around the implementation of InterRAI.  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 is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflected actions being implemented and signed off when completed.  Health and safety policies are implemented and monitored by the health and safety committee. The health and safety representatives interviewed confirmed their understanding of health and safety processes including recent law changes. They have completed the external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Radius has achieved tertiary level ACC Workplace Safety Management Practice.  Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.  A review of nine incident/accident forms identified that forms are fully completed and include follow-up by a registered nurse. Neurological observations are carried out two-hourly for any suspected injury to the head. The clinical manager is involved in the adverse event process.  The regional manager was able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Negligible | Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (the clinical manager, one registered nurse, three healthcare assistants, the cook, an activities coordinator and a cleaner) included a comprehensive recruitment process which included reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals.  A register of registered nursing staff and other health practitioner practising certificates is maintained.  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. The clinical manager holds overall responsibility for staff education. There is an attendance register for each training session and an individual staff member record of training.  Registered nurses are supported to maintain their professional competency. Three registered nurses (one is the clinical manager and one is the facility manager) have completed their InterRAI training. Difficulty accessing InterRAI training has resulted in the service being unable to meet all InterRAI contractual obligations. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. There is a minimum of one RN on site at any time. Activities are provided five days a week.  Staff working on the days of the audit, were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed report there are sufficient staff numbers. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files 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. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant HCA or nurse, including designation. Individual resident files demonstrate service integration. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager/registered nurse (RN) screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. |
| 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 | The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Registered nurses are responsible for the administration of medications and they complete an annual medication competency and attend medication education annually. Medication prescribed is signed as administered on the pharmacy generated singing chart. The facility uses a robotic sachet system for regular medications and blister packs for ‘as required’ medications. The RN on duty reconciles the delivery and documents this on the signing sheet. There were no self-medicating residents on the day of audit. Standing orders are not used. Medical practitioners write medication charts correctly and there was evidence of one to three monthly reviews by the GP. All 16 medication charts reviewed had photo identification and allergy status identified. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The service employs a Monday to Friday qualified head cook and a second cook (in training) for weekends. Kitchen hands support the cooks. All staff have attended food safety hygiene training and chemical safety.  There is a fully functional kitchen and all meals and baking is prepared and cooked on site. A food services manual is in place to guide staff. The cooks follow a rotating seasonal menu, which has been reviewed by the company dietitian. All recipes are readily accessible through the organisational intranet. Meals are served directly to residents in the dining room, from the kitchen and they are delivered in a hotbox to the second dining area. A resident nutritional profile is developed for each resident on admission and is provided to the kitchen staff. The head cook (interviewed) is notified of any dietary changes. Resident likes, dislikes, dietary preferences, modified and special diets are accommodated. There is special equipment available for residents if required.  The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. All food is stored appropriately and dated. Residents and the family members interviewed were satisfied with the quality and variety of food served. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. Appropriate assessment tools (paper based for some residents and InterRAI for some – link 1.2.7.5) were completed and assessments were reviewed at least six monthly or when there was a change to a resident’s health condition in files sampled. Care plans are developed based on the outcomes of assessments. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans reviewed described in detail, the support required to meet the resident’s goals and needs and identified allied health involvement under a comprehensive range of template headings. Residents and their family/whānau are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Registered nurses (RNs), (including the clinical manager) and healthcare assistants follow the detailed and regularly updated care plans and report progress against the care plan each shift. When a residents condition changes, the RN initiates a GP, NP or nurse specialist consultation or referral, for example to the district nurse. If external medical advice is required, this will be actioned by the GP.  Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.  Wound assessment, monitoring and wound management plans are in place for two residents with minor wounds, which are being appropriately managed. There were two pressure injuries (one facility acquired and one community acquired) on the day of audit. The service is proactive about wound management and photographic evidence and there is district nurse involvement in the management of the pressure injuries.  Care plan interventions including intentional rounding also used for turning charts, food and fluid charts demonstrate interventions to meet resident’s needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | CI | An activities person is employed fulltime and has been with the service five years. The activities person has commenced diversional therapy (DT) training. She has access to regional DT networks and support from the facility manager and from within the organisation. There are volunteers involved in the activity programme including entertainers, church groups, RSA visits and one-on-one time with residents. The service offers five-week placements for DT students. Exercise sessions are provided in a variety of forms to maintain interest and physical well-being for all groups of residents including weekly Tai Chi. The afternoon programme has allocated one-on-one time for hospital residents and for those who choose not to participate in the group activities. Activities and entertainment occur in the main lounge and the smaller lounge. Group activities reflect ordinary patterns of life such as baking, library books, board games, bowls, current affairs and arts and crafts. Outings into the community, to concerts and places of interest are planned. Special events are celebrated.  All long-term resident files sampled have a recent activities plan within the care plan and this is evaluated at least six monthly when the care plan is evaluated. Residents and families interviewed commented positively on the activity programme. Residents and families provide feedback on the activities through surveys, resident meetings and the six monthly MDT reviews.  Residential disability residents are encouraged and supported to engage in 1:1 and individual activities in the community with many attending social clubs. Van outings are planned more regularly for the younger people with disabilities. Some activities are provided specifically for this group in the smaller lounge. Exercise programmes are focused on the individual’s preference and include for example cricket and weight lifting in consultation with the physiotherapist.  The service has exceeded the required standard around the art therapy programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurses evaluate all initial care plans within three weeks of admission. In files reviewed the long-term care plan was evaluated at least six monthly or earlier if there is a change in health status. There is at least a three monthly review by the GP or NP. All changes in health status are documented and followed up. An RN signs care plan reviews. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files reviewed. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident’s condition had changed and the resident reassessed. Examples of close liaison with dietitians, physiotherapist, mental health staff and social workers were sighted in resident files reviewed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were stored safely throughout the facility. Safety datasheets are available. The two sluice rooms (one each wing) have personal protective clothing readily available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 23 December 2016. The building has a number of alcoves and lounge areas. 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. Essential contractors are available 24 hours. Hot water temperatures are monitored monthly and are maintained between 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. Residents have access to external areas that have seating and shade. There is an outdoor designated resident smoking area. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. Building is currently being undertaken to extend and refurbish the facility. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are an adequate number of communal toilets and shower/bathing areas for residents. Toilets and showers have privacy systems in place. One shower and two toilet areas have been renovated. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All resident’s 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 and residential disability residential care residents. Residents are encouraged to personalise their bedrooms. Electric beds and ultra-low beds are used for hospital residents and residential disability residents as assessed. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large main dining room adjacent to the kitchen. A smaller dining/lounge space is available for those residents who prefer to dine in a smaller group. A larger separate lounge area is available. There is safe and easy access to communal areas. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry including personal clothing is laundered off-site. There is a laundry area with facilities for hand washing of woollens, a sluice tub and commercial washing machine with a sluice cycle if needs. The laundry has defined dirty/clean areas. The two laundry/cleaning staff interviewed distribute all clean laundry to linen storage areas and personal clothing to the residents. 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. The cleaners’ trolley was well equipped and stored in designated locked rooms when not in use.  Residents and relatives interviewed were satisfied with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster manuals to guide staff in managing emergencies and disasters. 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 dated 19 January 1999. Fire drills take place every six months. Supplies of stored water and food are held on site and are adequate for three days. There is a gas barbeque and spare gas bottles. Civil defence bins/supplies are checked six monthly. Electronic call bells were evident in resident’s rooms, lounge areas, and toilets/bathrooms.  The facility is locked from 7pm with doorbell access that is linked to the nurse call system. The service has internal and external security cameras in place to promote resident safety. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and all resident rooms are appropriately heated with radiator heating that is adjustable in the resident’s rooms. The facility is well ventilated when required. All rooms have external windows that open allowing plenty of natural sunlight. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Radius Waipuna 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. A registered nurse is the designated infection control nurse with support from the acting facility manager, supporting regional clinical manager 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 2015. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | A registered nurse at Radius Waipuna 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. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are 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. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | 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. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | CI | Infection surveillance is an integral part of the infection control programme and is described in Radius’ infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually, and is provided to Radius head office. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality meetings and staff meetings and plans and interventions resulting from surveillance create improvements in a way that exceeds the required standard. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the acting facility manager. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers.  There were two residents using enablers and three hospital residents with restraints during the audit.  One resident file was reviewed where an enabler was in use. Voluntary consent and an assessment process were completed. The enabler is linked to the resident’s care plan and is regularly reviewed.  Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical manager) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. The restraint coordinator in partnership with the RNs, GP, resident and their family/whānau, undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations.  Ongoing consultation with the resident and family/whānau are evident. Two hospital-level residents where restraint was in use (lap belts and bed rails), were selected for review. The completed assessment considered those listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.  Restraint authorisation is in consultation/partnership with the resident and family and the GP. The use of restraint is linked to the residents’ care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in two resident files where restraint was being used.  A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly as part of the restraint committee meeting. A review of two resident files identified that evaluations are up-to-date. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint minimisation programme is discussed and reviewed at the monthly restraint meetings, attended by the restraint coordinator (clinical manager), RNs and HCAs. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme, and staff education and training. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Negligible | Three of the eleven RNs are certified InterRAI competent (one of these is the facility manager and another is the clinical manager). The service has a goal to have one RN per 15 residents capable of InterRAI assessments. Training was reported as having been difficult to access. The resulting lack of trained InterRAI staff means not all contractual obligations around InterRAI have been met. | Two residents (one hospital and one rest home) did not have an InterRAI assessment completed when risk assessments were reviewed in 2016. This is due to a turnover in staff and difficulty accessing InterRAI training. This is beyond the control of the provider. | Ensure that sufficient registered nurses are InterRAI trained to be able to meet contractual obligations.  180 days |

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

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.3.1  The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times. | CI | In 2014, Radius Waipuna identified that while the processes that were followed after the death of a resident were adequate and met requirements, there were actions that could be completed to improve the experience for staff, other residents and the loved ones of the deceased resident. | To improve the experience for staff, family of the deceased and other residents following the death of a resident, Radius Waipuna commenced a project in 2014 where a visual picture of an angel is placed on the bedroom door of the resident that has passed on. Along with that, another angel picture is placed on the time target machine where every staff member clocks into the shift before work. This has enhanced staff to know that family may be around the site and to be sympathetic to their loss along with informing staff that there is a resident lost to the whānau on site  Culturally it has indicated that a body is present in the bedroom so staff do not enter without knowledge of the manager unless otherwise indicated. It gives knowledge that goodbyes can be given to the resident with family permission. Allied staff are aware not to enter. There are now no surprises for staff members and they report that this valued their feelings as well as families, and it assisted in reducing any cultural issues that arose. The angel is not removed until the bedroom is blessed.  Results have demonstrated that this has improved the experience for those who have lost a loved one at Radius Waipuna. From June 2013 to June 2014, there were 21 deaths at the facility and no compliments received from families following the death. From June 2014 to June 2015, 25% (four) of the families of the residents who passed at the facility provided a written compliment around the way the process was managed. |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | Radius Waipuna provides several examples of good practice around activities, services to younger residents, the service provided following death and many improvements to the facility. | The service identified that pressure injuries with early detection are minimised through early reporting and prompt intervention. In January 2015, a project commenced to address this issue. The project included ensuring review processes according to Radius policy (six monthly). Early reporting on incident and accident forms was encouraged through training and monitoring to ensure that early intervention is analysed, photos are taken pre and post intervention, wound plans are created by the registered nurse in liaison with the clinical manager, and short-term care plans are then evaluated and reviewed at registered nurse meetings for educational purposes.  Education of detection has been given to staff for early reporting, along with wound education.  Service provision has improved on site. Findings with use of photos have assisted wounds healing quicker. Liaising with allied health and coordinating early intervention has assisted. Identification of difference between friction and pressure injuries has been identified as the key to decreasing pressure injuries along with health care assistant education around reporting. The number of grade one and two pressure areas has significantly decreased, the only reported grade three pressure area was in 2015 and there has never been a grade four pressure injury reported at Waipuna. |
| Criterion 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | CI | Radius Waipuna has a current business plan, and goals are developed annually and progress is reviewed regularly. | In 2015, Radius Waipuna introduced a visual focus for staff to explain the need for the business plan to remain goal focused with ‘5 star staff’ – ‘5 star service’ creating a homely environment and a de-institutional hospital approach to care and referring to individual care with a family/whānau focus.  The 2014-2015 business plan was produced and implemented, and feedback from resident’s surveys showed different feedback from past surveys, with residents happier with care and with more focus on a homely environment. Staff were further reminded of the plan with posters in the staff room representing rest areas and ticket collectors (similar to a bus journey), discussion at quality meetings around keeping the bus rolling, some flat tyres on the way then staff jumping back on the bus and starting again.  Service provision improved as staff understood the concept of the ‘5 star staff’ with ‘5 star service’, valuing of staff, and rewards with employee of the month and year, free vitamin C given over winter to assist with illness, food provided in staff room for breaks, pizza shouts, cultural days and shared lunches created a whānau based feeling. Service improved with less incidents and accidents, early reporting of quality faults and improvements at quality meetings.  Resident survey statistics were fed back to staff and compliments were shared with staff, which promoted a sharing, caring environment. Staff became peer evaluators with a focus of being accountable for all actions and interventions for residents. Healthcare assistants now have representatives that approach management with problematic areas, which can be discussed to work some tasks more efficiently on the floor.  Because of this project, overall resident satisfaction in the survey increased from 22% being very satisfied in 2014 to 40% in 2015. Similarly, in the 2014 survey 55% of respondents said they would recommend the facility and this increased to 80% in 2015. |
| 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 is reported as constantly being reviewed to ensure it encompasses the needs of different groups of residents with varying abilities and interests. | An art therapy project commenced in September 2015, with the aim to maintain physical, sensory, cognitive, social/emotional communication for residents of all ages. Nine residents were included in the database for attendance at art related activities. Resident participation in the smaller group art therapies has impacted positively on the quality of the lives of those participating. It includes: a) Physical maintenance of upper limb functions, strength, fine motor skills and dexterity and has reduced the incidence of contractures. b) Prompts past skills and interests, maintains alertness and attention skills. c) Small group participation has increased social interaction, reducing social isolation and risk of depression for those residents at risk and with dementia related illness. d) Self-esteem has increased by promoting self-expression.  Residents expressed satisfaction in gifting their artwork to their families. Their families verbally expressed satisfaction that their relative was now participating in activities and expressing enjoyment in art related activities. Artwork was proudly on display on the day of audit. Staff report residents are keen to get personal cares completed so they can get to art activities earlier in the mornings.  The data collated shows a marked increase in individual resident’s attendance from March to June 2016, with the highest attendance for art related activities in June this year, showing positive signs of productivity. |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | All infections at Radius Waipuna are reported on an infection reporting form and all infections are analysed monthly, by the infection control nurse, with a clear bulletin developed for staff and presented at the staff meeting describing specific targeted interventions. | The infection control nurse had a goal to reduce wound infections in 2016. All wound infections (and other infections) are analysed individually as they occur and collectively on a monthly basis with trends identified. A memo is developed with specific interventions for staff to implement to reduce the incidence and severity/duration of wound infections. This was visible in staff areas and is presented at monthly staff meetings with any education required to implement the interventions. Because of this project, wound infections have decreased by 50% in the first six months of 2016 compared to the same period in 2015. |

End of the report.