

# Radius Residential Care Limited - Radius St Joans Care Centre

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Radius Residential Care Limited
<b>Premises audited:</b>	Radius St Joans Care Centre
<b>Services audited:</b>	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 16 May 2017    End date: 17 May 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	81

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Radius St Joan's is owned and operated by Radius Residential Care Limited. The service provides care for up to 98 residents requiring rest home, hospital or residential disability level care (physical or intellectual). On the day of the audit, there were 81 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.

A registered nurse, with experience in aged care management manages the service. A Radius regional manager supports her. The clinical manager position was vacant at the time of the audit and the previous clinical manager was acting in the role. Residents and relatives interviewed spoke positively about the service provided.

The service has exceeded the standard around community engagement, the activities programme, food service and restraint minimisation. This audit has identified an area for improvement around the vinyl floor in bathrooms in two wings.

## 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.
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Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code. 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 can 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.		Standards applicable to this service fully attained.
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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, 7 days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

## 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.		Standards applicable to this service fully attained.
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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 or enrolled nurses with registered nurse oversight 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 can be provided. Residents and relatives interviewed were complimentary about the food service.

## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy. 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 can be ventilated and heated. The outdoor areas provide seating and shade.

There is an approved evacuation scheme and emergency supplies available. There is a minimum of one first aid trained staff member on every shift.

## Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enabler. During the audit, there were no residents using restraints and one resident was using an enabler. 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.

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 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. A norovirus outbreak in September 2016 was well managed.

## 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)
<b>Standards</b>	3	42	0	1	0	0	0
<b>Criteria</b>	4	89	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>Radius St Joan’s 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 (five healthcare assistants– four from the hospital and one from the rest home, four registered nurses, one enrolled nurse and one motivational therapist) confirmed their understanding of the Code. Nine residents (four rest home and five hospital level- including two on younger persons with disabilities contracts and one on a convalescent care contract) and three relatives (all hospital level) interviewed confirmed that staff respect privacy and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed</p>	<p>FA</p>	<p>Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their EPOA. Advanced directives are signed for separately. There was evidence of discussion with family when the GP completed a clinically</p>

<p>choices and give informed consent.</p>		<p>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.</p> <p>Nine of nine resident files sampled (four from the rest home- including one resident with an intellectual disability and five from the hospital- including two residents with physical disabilities) had a signed admission agreement and consents. For the PACC resident (convalescent care contract) the agreement is a DHB document that is signed by the resident.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>CI</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. 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. Relatives and friends are encouraged to be involved with the service and care. Key people involved in the resident's life are documented in the care plans and 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 and community participation has earned them a continuous improvement rating. There are several ways St Joan's support ongoing access to community services (eg, 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>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</p>

		process. Staff interviewed could 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). Five complaints were received in 2016 and one complaint made in 2017 year to date. Follow-up letters, investigation and outcome was documented. Corrective actions have been implemented and any changes required were made as a result of the complaint. There is evidence of lodged complaints being discussed in manager and staff meetings.
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.	FA	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 September 2016 and the results showed that most 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. Residents interviewed confirmed their values and beliefs were considered. Interviews with HCAs described how choice is incorporated into resident cares.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability	FA	The Māori health plan for the organisation references local Māori healthcare providers regionally within New Zealand and provides

<p>needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Māori consultation is available through the documented iwi links (Ati Hou Nui O Paparangi) and Māori staff who are employed by the service. A whānau member of a resident was identified as the kaumātua for the facility. During the audit, there were four residents that identified as Māori. One Māori resident file reviewed confirmed that Māori cultural values and beliefs are being met and are addressed in the Māori health care plan.</p>
<p>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.</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 multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>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.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>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 RNs from the local DHB. Radius have provided a Radius roving clinical manager to support the clinical manager in their absence. Outcomes for the service are monitored with benchmarking across all Radius facilities. Feedback is provided to staff via the various meetings and through graphs and notices on the noticeboard in the staff room. There is a minimum of two RNs on the night shift with additional RNs on the morning and afternoon shifts. A physiotherapist is available twelve hours a week. Registered nurses and HCAs were described by residents and family as being caring.</p>

		Examples that confirm good practice include (but are not limited to): increased staff attendance at meetings and in-service education; toolbox talks and staff questionnaires in order to assist staff in completing compulsory training; continuation of the staff personal development training including the management team completing communication training in order to engage in a more effective manner with staff, residents and families. In 2016, St Joan's was awarded the Radius Managing Director's award for clinical excellence: "Recognition of outstanding performance" by a Radius Care facility.
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 15 incident reports 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.	FA	Radius St Joan's is part of the Radius Residential Care Group. St Joan's cares for up to 98 residents requiring hospital and rest home level care and residential disability (physical and intellectual) support. There are separate wings for rest home and hospital level care. On the day of the audit, there were a total of 81 residents (37 rest home level residents- including 1 resident on young persons with disability (YPD) contract receiving residential disability (physical) support and 1 resident on a short-term convalescent care contract). There were 44 hospital residents (including 1 on long-term support- chronic health conditions (LTS - CHC) contract and 6 residents on YPD contracts- 5 receiving residential disability (physical) support and 1 receiving residential disability (intellectual) support). There were no residents on respite at the time of the audit.  The Radius St Joan's business plan April 2017 to March 2018 is linked to the Radius Care Group strategies and business plan targets. The mission statement is included in information given to new residents. An organisational chart is in place. Comprehensive quarterly reviews are undertaken to report on achievements towards meeting business goals.  The facility manager is a registered nurse (RN) and has been in the

		<p>position for four years. At the time of the audit, the clinical manager role was vacant with the previous clinical manager acting in the role. The regional manager supports the facility manager in the management role and was present during the days of the audit. The facility manager has maintained more than eight hours of professional development activities related to managing an aged care facility.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager covers during the temporary absence of the facility manager. The regional manager or facility managers of other Radius facilities are also available for support.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></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 managers reflected staff involvement in quality and risk management processes. Resident meetings are bi-monthly. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. Survey results reflect increasing satisfaction.</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 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. 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.</p> <p>Health and safety policies are implemented and monitored by the Health and Safety Committee. The health and safety representative</p>

		(kitchen manager) interviewed confirmed her understanding of health and safety processes including recent law changes. She has 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.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. A review of 15 incident/accident forms identified that forms are fully completed and include follow up by a RN. Neurological observations are carried out two-hourly for any suspected injury to the head. The facility manager and regional manager could identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. One unexpected death was referred to the coroner.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Ten staff files reviewed (one facility manager, three RNs, three HCAs, one kitchen manager, one motivational therapist and one maintenance person) 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 RN staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. Staff are required to complete written core competencies during their induction. These competencies are repeated annually. There is an implemented annual education and training plan</p>

		that exceeds eight hours annually. All staff participate in continuing education relevant to physical disability and young people with physical/intellectual disabilities. 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. Five of ten RNs (including the facility manager) have completed their interRAI training.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. There is a minimum of one RN on-site at any time.</p> <p>In the rest home; there is one RN on duty in the AM and PM shifts. Additionally, there is one EN on duty in the rest home in the AM shift. The RN's are supported by adequate numbers of HCAs. In the rest home, there are three HCAs on duty in the AM shift, two HCAs on the PM shift and one HCA on the night shift.</p> <p>In the hospital units, there are four RNs on duty in the AM shift, two RNs on the PM shift and one RN on the night shift. Additionally, there is one EN on duty in the hospital, in the AM shift. The RN's are supported by adequate numbers of HCAs. In the hospital units, there are nine HCAs on duty in the AM shift, six HCAs on the PM shift and three HCAs on the night shift.</p> <p>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.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The 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.</p>
<p>Standard 1.3.1: Entry To Services</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to</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>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.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. In the short-term files sampled for one resident reviewed on the convalescent care contract, a discharge plan was included within the referral from the DHB (the sample was extended to include the second convalescent care file around discharge planning).</p>
<p>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.</p>	<p>FA</p>	<p>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, enrolled nurses and senior healthcare assistants 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 signing 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 four self-medicating residents on the day of audit and all had a current assessment confirming their ability to manage medications. 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 18 medication charts reviewed had photo identification and allergy status identified.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service employs a Monday to Friday qualified kitchen manager, two assistant cooks and nine kitchen hands. Kitchen hands support the cooks. All staff have attended food safety hygiene training and chemical safety. A food safety plan was signed off by the Ministry of Primary Industries in March 2017.</p> <p>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 main dining room, from the kitchen and they are delivered in hot boxes to the other dining areas. A resident nutritional profile is developed for each resident on admission and is provided to the kitchen staff. The kitchen manager (interviewed) is notified of any dietary changes on a specific form which is signed by the kitchen manager once sighted (documented in every file sampled). Resident likes, dislikes, dietary preferences, modified and special diets are accommodated. There is special equipment available for residents if required. These are documented for each area on a clipboard in the kitchen and were noted to include allergies for a short stay resident.</p> <p>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.</p> <p>The activities team and kitchen teams have collaborated to provide a monthly breakfast club that exceeds the required standard.</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>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.</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>All appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. Appropriate assessment tools (a suite of paper based for all residents and interRAI assessments for residents under the ARCC)</p>

		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.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>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. The convalescent care file reviewed had a short stay care plan documented that included the requirements of the referral from the DHB and interventions to ensure these were met. 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.</p>
<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>Registered nurses (RNs), enrolled nurses and healthcare assistants follow the detailed and regularly updated care plans and report progress against the care plan each shift. When a resident's condition changes, the RN initiates a GP or specialist consultation referral (eg, to the district nurse). If external medical advice is required, this will be actioned by the GP.</p> <p>The psychogeriatrician and mental health nurse for older people interviewed, reported a very high standard of care for the residents they work with. They reported the expertise of the staff and management meant that St Joan's can manage complex residents and that residents who may otherwise require a higher level of care are well managed at St Joan's.</p> <p>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.</p> <p>Wound assessment, monitoring and wound management plans are in place for residents with wounds (sixteen skin tears for eleven residents, one open wound, four ulcers, one abrasion, one scratch and one haematoma), which were being appropriately managed. There was one stage II pressure injury on the day of audit caused by a new shoe. The service is proactive about wound management and there is district</p>

		<p>nurse involvement in the management of the pressure injuries.</p> <p>Care plan interventions including intentional rounding also used for turning charts and food and fluid charts, demonstrated interventions to meet resident's needs.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>A motivational therapist is employed full-time and has been with the service over 20 years. She is supported by an activities coordinator. Exercise sessions are provided in a variety of forms to maintain interest and physical well-being for all groups of residents. Time is allocated for 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 lounges. 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.</p> <p>All long-term resident files sampled have a recent activity 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.</p> <p>Residential disability residents are encouraged and supported to engage in one-on-one time 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. Exercise programmes are focused on the individual's preference in consultation with the physiotherapist.</p> <p>The service has had Wi-Fi and ultra-fast broadband installed and this service is available to residents. Residents including two younger residents use this service to access emails and social media.</p> <p>Residents and family interviewed described a varied and interesting activities programme that was constantly reviewed to meet the current needs and interests of residents.</p>

<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 registered nurses evaluate all initial care plans within three weeks of admission. In long-term files reviewed, the long-term care plan was evaluated at least six-monthly or earlier if there is a change in health status. A multidisciplinary review had been completed annually for all long-term resident files sampled that included input from the multidisciplinary team, including the resident and/or a family member. In files sampled, all changes in health status were documented and followed up. An RN signs care plan reviews. Short-term care plans sampled were evaluated regularly (at least every three days) and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files reviewed. Short-term care plans sighted included issues such as bruising, infections, skin tears and behaviour management. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (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>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. In files reviewed, examples of close liaison with dietitians, physiotherapist, mental health staff and hospice was evident. A communication form is used whenever a resident visits a specialist or external provider (including GP's other than the contracted GP's) to document the purpose of the visit, any changes required and the timeframe for the next review. These forms were completed in files sampled.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were stored safely throughout the facility. Safety datasheets are available. The sluice</p>

		rooms have personal protective clothing readily available.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>The building has a current building warrant of fitness that expires 1 December 2017. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. The facility is well maintained except the vinyl in the bathrooms in two wings. 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 below 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. A sensory garden is in the process of being completed and one resident with a particular interest in gardening has an allocated garden area. 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. Several improvements have been made to the building since the previous audit. These have included:</p> <ul style="list-style-type: none"> <li>• Some individual room floors have been re-covered in wood panel vinyl or carpet</li> <li>• The main hallway from Norman and Charlotte wings, the reception area, offices and visitors lounge have been re-carpeted.</li> <li>• The driveway and car parks have been repainted</li> <li>• A new sluice for the rest home has been installed</li> <li>• Four shower rooms in the rest home have been newly fitted and painted</li> <li>• Lighting in the rest home hallways has been upgraded.</li> </ul>
<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>	FA	<p>There are an adequate number of communal toilets and shower/bathing areas for residents (link 1.4.2.4). Rooms in the Jebson and Doris wings have individual ensuites. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>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.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The building has several small and large lounge areas including a main lounge in the rest home and a lounge for each of the Charlotte, Laura and Norman hospital wings and a large combined lounge and dining area for the Jenson and Doris wings (all hospital level). There is also a main large dining area. There is safe and easy access to communal areas.</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>	CI	<p>All laundry including personal clothing is laundered on-site. There is a large laundry area with facilities. There are clear clean and dirty areas including an entrance for dirty laundry and an exit for clean laundry, a sluice tub and commercial washing machines with a sluice cycle if needed and driers. The laundry is staffed seven days per week. The cleaner interviewed identified that 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 and laundry service in the facility. The cleaners' trolley was well equipped and stored in designated locked rooms when not in use.</p> <p>In January 2017, a project to review the cleaning processes begun and this exceeds the required standard.</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 a comprehensive emergency management plan to guide staff in managing emergencies and disasters. The services emergency management plan considers the special needs of young people with disabilities in an emergency. 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 fire drill occurring on 23 March 2017. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of</p>

		orientation of new staff and ongoing training. Civil defence bins/supplies are checked six-monthly, last check occurred in March 2017. Civil defence backpacks are available in each wing (sighted). There is sufficient water stored for three litres per day for three days per resident. There are alternative cooking facilities available with a gas barbeque and gas hobs in the kitchen. Electronic call bells were evident in resident's rooms, lounge areas and toilets/bathrooms. The facility is locked at night with doorbell access that is linked to the nurse call system. The service has 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 oil heaters or heat pumps and a climate control system in the newer areas of the facility. Heating 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 St Joan's 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 facility 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 2016.
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 St Joan's is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the quality management team and care staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are Radius infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>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 (link CI 1.4.6.2). If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the acting facility manager. An outbreak in September 2016 involving 25 residents was well contained and managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p>

		During the audit, there were no residents using restraints and one resident was using an enabler. 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 management of challenging behaviours.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	CI	The service is proactive in reviewing residents who may otherwise require restraint and identifies alternative strategies to maintain a nil restraint environment. The required standard has been exceeded.

## 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 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	The building compliance audit in May 2016 identified that the vinyl flooring in the bathrooms in Laura and Norman wings was beginning to split. A corrective action plan was developed and the issue referred to head office. Repair was delayed while options were investigated including a full refurbishment of the two wings. This option has been decided against and at the time of the audit, quotes to replace the vinyl in these bathrooms had been obtained but the repair had not yet been completed.	The vinyl flooring in bathrooms in the Norman and Laura wings has split.	<p>Continue the plan to have the flooring in bathrooms in the Norman and Laura wings repaired.</p> <p>90 days</p>

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

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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 1.1.12.2</p> <p>Consumers are supported to access services within the community when appropriate.</p>	CI	<p>Key people involved in the resident's life are documented in the care plans and 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 and community participation.</p>	<p>The service sees itself as part of the local community and links closely with many community groups. In May 2016, the motivational team identified 10 residents with cognitive impairment/mild dementia. These residents showed decline in communication, some agitation and anxiety. Seven of the ten residents identified had past experiences working with children. The motivational team set up bi-monthly visits with early learning centres that could visit St Joan's on a regular basis. These early learning centres were also accessible by taxi or within walking distance.</p> <p>Kindergarten children with their carers came to have activities at St Joan's, such as the children reading to the group of 10 residents, having sing-a-longs and doing art and crafts with the</p>

			<p>children. The children would entertain the resident group with small performances (eg, singing Christmas carols and performing Kapa Haka). The residents responded visibly with the children and were immediately rewarded by the interaction. The resident group also visited the kindergarten for morning tea, including being shown around the children's work and favourite activities.</p> <p>The outcome of these bi-monthly visit demonstrates of benefit to the group of 10 residents. None of the ten residents have required additional medication, or have shown a decline in mobility and they have shown improvement in their communication abilities. Of the ten residents identified, six of the residents have been discharged from the Mental Health for Older Person Service since this initiative was introduced. Due to the success of the initiative, the kindergarten group have also requested to increase their visits from bi-monthly to four to six-weekly, with the aim to set up an adopt a grandparent/child concept.</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	<p>When a resident is admitted or nutritional needs change, the registered nurse or enrolled nurse completes a dietary requirement form and this is provided to the kitchen. All forms sighted, including that for the convalescent care resident, had been signed by the kitchen manager and any special needs, allergies or likes and dislikes are documented on a clipboard in the kitchen. In mid-2016, the kitchen and activities staff provided a pink ribbon breakfast that identified that rest home residents especially enjoyed the cooked breakfast. A project was developed and resulted in a monthly breakfast club that exceeds the required standard.</p>	<p>In 2016, a goal was developed to increase resident enjoyment of meals and increase participation in activities. A pink ribbon breakfast was held in June 2016 and family members were encouraged to attend as well. During 2016, the service provided two optional breakfast mornings for all residents in the facility. This was not well received by hospital residents but rest home residents were keen to continue with this. The first breakfast was attended by ten rest home residents and three hospital residents. The breakfast club was discussed at the February 2017 meeting and residents elected to have this every 3rd Tuesday of the month. The number of</p>

			<p>residents attending has increased from the initial 10 rest home and 3 hospital residents, to 27 rest home residents regularly attending throughout 2017 to date. Rest home residents and family members interviewed commented specifically and positively about the breakfast club and report looking forward to both the social environment and the cooked breakfast it provides.</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>CI</p>	<p>Cleaning and laundry processes are regularly reviewed and in early 2017, a project was initiated to improve cleaning processes and equipment with an aim to reduce infections and improve safety.</p>	<p>In late 2016, the service determined that a change in cleaning products and processes could improve the cleaning service and improve resident outcomes, particularly infection rates which were sometimes above the Radius benchmark.</p> <p>The preparation phase commenced in January 2017 and included: upgrading of all cleaners trolleys to trolleys that are ergonomically designed to enable ease of use and can fit all cleaning microfiber cloths and microfiber mop heads; the changing of all chemical stations; the changing of all soap dispensers and hand sanitiser dispensers; the setting up the laundry programme to accommodate a new laundry dispenser and to enable safe wash programmes; and the introduction of disposable cleaning equipment such as wipes and disposable mop heads for a client with a multi-resistant infection. In February 2017, all housekeeping staff and laundry staff attended training regarding the use of the new cleaning equipment, chemicals and the new material safety datasheets. This was reiterated in April 2017 when the new chemical and equipment providers held a 30 minute in-service, focusing on identifying high touch surface areas in different rooms within the facility. The new cleaning processes have</p>

			resulted in a reduction in skin infections, UTI's and chest infections to below the Radius average since March 2017.
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>	CI	<p>At the beginning of February 2014, the service identified the need to reduce the numbers of residents with restraints as there had been 11 restraints used across the facility in January 2014. The clinical team developed a quality improvement initiative plan to eliminate the use of restraint within the facility. There is evidence of action taken based on findings that have resulted in improvements that have had positive impacts on resident safety.</p>	<p>Radius St Joan's has a goal to maintain a restraint-free environment. To achieve this they implemented the following interventions: (i) Individual assessments and care plans that reflect resident needs; (ii) Individual resident habits are identified and reflected to indicate walking times; (iii) Alleviating boredom by escorting residents to activities; (iv) Personal resident motivation during awake hours, including increasing socialisation; (v) Family members are educated on the hazards of restraints associated with the use of restraints; and (vi) Staff are educated on individual needs and receive annual restraint minimisation training.</p> <p>Restraint minimisation training, challenging behaviour and de-escalation techniques are still audited every six months and remain as a point of discussion at the full staff/quality meeting. Restraint minimisation training is provided annually to all staff and at the orientation programme for all new staff. As a result of these interventions, the service has maintained a restraint-free environment since August 2016 despite having 42 hospital level residents.</p>

End of the report.