

Radius Residential Care Limited - Radius Potter Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Radius Residential Care Limited

Premises audited: Radius Potter Home

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: 2 March 2016 End date: 3 March 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: 55

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
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

Potter Home is owned and operated by Radius Residential Care Limited and cares for up to 57 residents requiring rest home, hospital or residential disability level care. On the day of the audit there were 55 residents. The service is managed by a registered nurse with experience in aged care management. She is supported by a Radius regional manager and a clinical manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

This 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 quality data, an infection control project and interventions provided producing better than expected outcomes for residents.

This audit has identified an area for improvement around interRAI assessments.

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 receives ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

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

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.

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.

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.		Some standards applicable to this service partially attained and of low risk.
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Entry to the service is managed primarily by the registered nurses or clinical manager. There is comprehensive service information available. Initial assessments are completed by a registered nurse. Care plans and evaluations are completed by the registered nurses 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 an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Medications are 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.
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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 except two bedrooms are single occupancy and several have their own ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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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. A register is maintained by the restraint coordinator. During the audit, two residents were using restraints and six residents were using enablers. Staff regularly receives education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation. The IC programme 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 also 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	2	47	0	1	0	0	0
Criteria	3	97	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Radius Potter 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 receives training about resident rights at orientation and as part of the annual in-service programme. Interviews with care staff (four health care assistants (HCAs) who work across the rest home and hospital on the am, pm and night shifts, two registered nurses (RNs), one enrolled nurse (EN) and one activities coordinator) confirmed their understanding of the Code. Nine residents (two rest home level, five hospital level and two young persons with disability) and eight relatives (seven hospital level, one rest home 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 choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their EPOA. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Health care assistants and registered nurses</p>

		<p>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>Eight of eight resident files sampled (three from the rest home, three from the hospital and two for residential disability) had a signed admission agreement and consents.</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>	FA	<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>	FA	<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 and regular visits to the local swimming pool. Relatives and friends are encouraged to be involved with the service and care.</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>	FA	<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 process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register that 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. This includes one complaint lodged with HDC on 7 May 2015 that was signed off on 27 November 2015 with all required actions</p>

		completed. There was one unsubstantiated complaint lodged with the district health board.
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 April 2015 and the results showed that overall resident experience was reported as being good or very good by the vast majority of respondents. Residents and relatives interviewed confirmed that staff treated residents with respect. The service has a philosophy that promotes quality of life and involves residents in decisions about their care (link CI 1.1.8.1). 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.
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 policy 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. Cultural activities include but are not limited to celebrations around food (eg, hangi) and speaking te reo Māori to

		those residents who identify as Māori. At the time of audit there was one resident who identified as Māori and confirmed their cultural needs were being met by the service (link CI 1.1.8.1).
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	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 take into account their values and beliefs.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Staff job descriptions include responsibilities. The monthly staff (team) 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>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>Policies and procedures are aligned with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.</p> <p>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. The service has been part of the 'do no harm' project. Positive outcomes have been identified by the service as a result of the utilisation of knowledge. Outcomes for the service are monitored with benchmarking across all Radius facilities and with other facilities through the DHB e.g., through the 'do no harm' project around falls. Feedback is provided to staff via the various meetings.</p> <p>There is a minimum of one registered nurse on each shift and HCAs are described by residents and family as being caring and competent. A number of process improvements have been implemented resulting in improvements to resident wellbeing.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 15 adverse events reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member.</p> <p>There is an interpreter policy in place and contact details of interpreters were available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Radius Potter Home is a Radius aged care facility located in Whangarei. The facility is certified to provide rest home, hospital and residential physical disability care for up to 57 residents. Fourteen beds are dedicated to rest home level of care. There are six additional dual purpose beds.</p> <p>Fifty-five residents were living at the facility during this audit. Forty-six residents were on the Aged Related Care contract (seventeen rest home level and twenty-nine residents hospital level, one (hospital level) resident was on the Long Term Chronic Conditions contract (LTCC) and eight residents were on the YPD contract (five hospital level and three rest home level).</p> <p>The 2014-2017 business plan describes the vision, values and objectives of Radius Potter Home. Annual goals are linked to the business plan and reflect regular reviews via regular meetings and monthly reports to the regional manager.</p> <p>The facility manager is a registered nurse with many years' experience in aged care management. She has been in the role since January 2013 and is supported by a regional manager.</p> <p>The facility manager has maintained at least eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The clinical manager/RN covers during the temporary absence of the facility manager. The regional manager or facility managers of other Radius facilities in Whangarei are also available.</p> <p>The facility manager was on leave during the audit and the regional</p>

		manager and clinical manager were covering in her absence.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the managers (regional manager, clinical manager/RN), the GP and staff (four HCAs, two RNs, one EN, one kitchen manager, one activities coordinator, one cleaner, one maintenance staff) reflected staff involvement in quality and risk management processes.</p> <p>Resident meetings are monthly. In addition there are regular men's meetings and women's meetings. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. Survey results reflect high levels of satisfaction.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level by the clinical managers group with input from facility staff every two years. Clinical guidelines are in place to assist care staff. Updates to policies included procedures around the implementation of interRAI.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements to a standard that exceeds the requirements. 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. Two health and safety representatives interviewed confirmed their understanding of health and safety processes. They have both completed the stage one 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</p>

		<p>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.</p> <p>Falls prevention strategies are in place. The facility was part of the First Do No Harm project in Whangarei from June 2014 – June 2015. Quality initiatives have been implemented to reduce the number of falls (link to CI 1.2.3.6).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to 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.</p> <p>A review of fifteen incident/accident forms (eight falls, five skin tears and two pressure injuries) identified that forms are fully completed and include follow up by a registered nurse. Neurological observations are done two hourly for any suspected injury to the head. The clinical manager is involved in the adverse event process.</p> <p>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.</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. Eight staff files reviewed included a comprehensive recruitment process which included reference checking, signed employment contracts, job descriptions, police checks, completed orientation programmes and annual performance appraisals.</p> <p>A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. The EN holds overall responsibility for staff education. There is an attendance register for each training session and an individual staff member record of training. Twenty-eight HCA's are employed with 54% (15) having completed their</p>

		<p>basic aged care education (ACE) training. Eight (29%) have completed their level 3 ACE with 46% in progress of completing theirs. Three have completed their dementia qualifications. Specific training is provided around looking after younger people with disabilities.</p> <p>Registered nurses are supported to maintain their professional competency. Two registered nurses have completed their interRAI training. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	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 and three HCAs on site at any time. HCAs are routinely assigned to the same residents to enhance the continuity of care (link to CI 1.1.8.1). Activities are provided five days a week.</p> <p>Staff working on the days of the audit were visible and were 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. Entries are legible, dated and signed by the relevant HCA or nurse including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>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 clinical manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the clinical manager. The</p>

		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>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<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. One resident file sampled for a resident who had improved in health status and returned to independent living (link CI 1.1.8.1) contained clear documented discharge planning, liaison with other services and identification and management of potential challenges and risks.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication round sighted. Medication prescribed is signed as administered on the pharmacy generated signing chart. Registered nurses administer medicines. All staff that administers medication are competent and have received medication management training. The facility uses a blister pack medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medication charts are written correctly by medical practitioners and there was evidence of three monthly reviews by the GP. Two current residents self-administer medicines and have current competency assessments.</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>	FA	<p>There is a fully functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the kitchen manager works closely with the</p>

		RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy 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 residents should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools (paper based for some residents and interRAI for some) were completed. 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 on the basis of these 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. Radius Potter Home are proactive in ensuring that residents are provided with the very highest standard of care and the best available interventions to ensure the most positive possible outcomes. The registered nurses review residents changing needs frequently (sometimes daily) and update care plans whenever increased or different needs (sometimes to allow increasing independence). External specialists are referred to promptly and their recommendations are included in care plans. 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	FA	Registered nurses (including the clinical manager) and healthcare assistants follow the detailed and regularly updated care plans and

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>report progress against the care plan each shift. If external nursing or allied health advice is required, the RNs will promptly initiate a referral (eg, to the district nurse). If external medical advice is required this will be actioned by the GP. Staff has access to sufficient medical supplies (e.g., 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 16 residents with 20 minor wounds, which are being appropriately managed. The wound rate at the facility appears high as even the most minor wounds (e.g. a scratch) are actively managed with a wound assessment and plan. The service is proactive about wound management. Photographic evidence and specialist documentation in resident files sampled, demonstrate that very complex wounds have been actively and positively managed. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Care plan interventions including intentional rounding, turning charts and food and fluid charts demonstrate interventions to meet resident's needs.</p> <p>The service has exceeded the required standard around the interventions implemented to exceed expected outcomes for residents.</p> <p>The service often exceeds the expectations of residents, families and external services and referrers as confirmed by the dietitian and the GP and in the following four examples (also link 1.1.8.1):</p> <p>Resident one (a residential disability resident): Admitted for long term care requiring two hourly turns, feeding, catheterisation and using a sling hoist to transfer. At the time of the audit, this resident transfers with the assistance of one carer, walks with a frame and can take a few steps independently and is taking to a weekly exercise activity. The resident feeds themselves and is supported to use the toilet when they request. Strength building exercises including wearing weights and doing sit ups are current activities. The resident reported arriving at the facility with a poor prognosis and that their whole life is now improved.</p> <p>Resident two: Admitted with a long term chronic wound that specialists documented was life threatening and was unlikely to heal. The resident uses a hoist to transfer and a wheelchair for mobility. Close liaison with</p>
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		<p>wound nurse specialist, input from the dietitian, staff vigilance and education around wound care and disease management have resulted in the resident now mobilising independently around the facility with a walking frame and the wound is robustly healed.</p> <p>Resident three: Admitted for palliative care requiring an air mattress, with very low body weight, dependant for all cares and a high fall risk. The resident was discharged home with minimal support following stoma nurse and staff input to self-manage a stoma. Close liaison between the staff, the resident, the GO and the dietitian to increase body weight and nutritional status. Physiotherapy input to mobilise independently with a frame and staff support and education to retrain the bladder to now be continent.</p> <p>Resident four: On admission, required two staff and a sling hoist for all transfers, unable to turn self and dependant for all continence needs. Now transfers self, walks well with a walker for short distances, is a moderate falls risk and has been provided with education around this. The resident is able to take several days leave at a time to attend cultural events where family have been taught by Potter Home staff to attend to the greatly reduced needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>An activities coordinator is employed full time to operate the activities programme for all residents. Each resident has an individual activities assessment on admission and from this information, an individual activities plan is developed as part of the care plan by the registered nurses with input from the activities staff. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. 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.</p> <p>Residential disability residents are encouraged and supported to engage in 1:1 and individual activities in the community with many attending social clubs and similar. Some activities are provided specifically for this group in the lounge in the younger people's wing.</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>All initial care plans are evaluated by the registered nurses within three weeks of admission. In files sampled, 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. All changes in health status are documented and followed up. Care plan reviews are signed by an RN. 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 sampled. 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 was reassessed. Examples of close liaison with dietitians, physiotherapists, mental health staff and social workers were sighted in resident 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 stored safely throughout the facility. Safety data sheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness. The building has a number of alcoves and lounge areas. There is a full time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely</p>

		<p>deliver the cares as outlined in the resident care plans.</p> <p>The eight residential disability residents reside in a separate wing with an open plan lounge and dining room and a large single room each. These residents reported enjoying the environment they reside in.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Several bedrooms have their own ensuite and some have shared 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 residents rooms are of an appropriate size to allow cares to be provided and for the safe use and manoeuvring of mobility aids including those required by hospital level care residents. Residents are encouraged to personalise their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The communal areas include the main lounge, several smaller loungers and separate dining areas. The communal areas are easily and safely accessible for residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is done off site except kitchen laundry, personal items, face clothes and hand towels which are managed in the on-site commercial laundry by dedicated laundry staff. Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during</p>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. There is a minimum of one first aid trained</p>

<p>emergency and security situations.</p>		<p>staff member on every shift and during outings. The facility has an approved fire evacuation plan. Fire drills take place every six months. Smoke alarms, sprinkler system and exit signs are in place. Gas barbeques and torches are available in the event of a power failure. Emergency lighting is in place which is regularly tested. A civil defence kit is in place. Supplies of stored water and food are held on site and are adequate for three days. Electronic call bells are evident in resident's rooms, lounge areas and toilets/bathrooms.</p> <p>The facility is kept locked from dusk to dawn. The service utilises a security camera to promote resident safety.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Radius Potter Home 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 KPI's. 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.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>An enrolled nurse (supported by the clinical manager) at Potter Home 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.</p>

		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	There are Radius infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	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 are appropriate to their needs and this is documented in medical records.
<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>	CI	<p>Infection surveillance is an integral part of the infection control programme and is described in Radius's 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 on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Radius head office. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality meetings and staff meetings. 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.</p> <p>The service has exceeded the standard around the use of surveillance activities to improve outcomes for residents.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	FA	Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective.

<p>minimised.</p>		<p>Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers.</p> <p>There were six residents using enablers and two hospital residents with restraints during the audit.</p> <p>One resident file was reviewed where an enabler (wheelchair lap belt) 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.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis (link to CI 1.2.3.6), and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	<p>FA</p>	<p>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.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. One hospital level resident where restraint was in use (lap belt and bed rails) was selected for review. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>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.</p> <p>Restraint authorisation is in consultation/partnership with the resident,</p>

		<p>family and the GP. The use of restraint is linked to the resident's 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 one resident file where restraint was being used.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>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 one resident file identified that evaluations are up-to-date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint minimisation programme is discussed and reviewed at the monthly restraint meetings, attended by the restraint coordinator (clinical manager) and RNs. 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.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	The service has begun to meet the interRAI contractual requirements but not all residents required to have an interRAI assessment had one. The clinical manager and regional manager report that accessing interRAI training has been difficult but that staff are booked to complete training. Currently the clinical manager and one registered nurse are interRAI trained. All residents have comprehensive paper based assessments completed and reviewed within contractual timeframes.	One of two residents (a rest home resident) in the file sample admitted since July 2015 did not have an interRAI assessment completed and the one resident in the file sample who had risk assessments reviewed in 2016 (a hospital resident) did not have these completed using the interRAI tool.	<p>Ensure contractual requirements around interRAI use are met.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has been part of the 'do no harm' project. Positive outcomes have been identified by the service as a result of the utilisation of knowledge. Outcomes for the service are monitored with benchmarking across all Radius facilities and with other facilities through the DHB e.g., through the 'do no harm' project around falls. A number of process improvements have been implemented resulting in improvements to resident wellbeing.</p>	<p>Radius Potter Home has an ethos that expectations should always be exceeded and they aim to apply this to all aspects of the facility including documented resident interventions. The service has provided examples where interventions have resulted in positive outcomes for residents that were initially not expected.</p> <p>The service identifies a goal to improve the quality of life for all residents.</p> <p>A number of strategies are implemented to complement each other to provide the best support and assistance possible to residents. Strategies include a high level of physiotherapy input, staff education that is focused toward motivating residents and individualised care, strong leadership that encourages staff to aim high and suggest ideas they believe could assist</p>

			residents, strong relationships with allied health providers, very comprehensive care plans that are updated very frequently and instilling hope and providing motivation for residents and families. Staff are rostered to work in the same areas so that they are familiar with the detailed needs of residents. Four of eight files reviewed identified improvement in resident health status since admission (link 1.3.6).
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	Robust quality and risk management systems are in place which included the collection of falls data identifying a trend that resulted in a successful quality initiative around reducing the number of falls in residents' rooms. Quality data is regularly shared with staff via regular team meetings and handovers.	Quality initiatives have resulted in a reduction in the number of falls. Falls data that was collated and trended, reflected a high incidence of falls occurring in residents' rooms (17 falls during the month of October 2015). Strategies implemented included a) encouraging residents who had fallen in their rooms to spend greater amounts of time in the lounge and participating in activities, b) implementing intentional rounding logs to closely monitor residents at risk of falling in their rooms, c) training HCAs to anticipate residents' needs in advance and ensure frequent toileting as per care plans and d) increasing fluids and close monitoring of residents for infections (eg urinary tract infections that may cause confusion). Trends in data reflect a steady decline of residents who have fallen in their rooms over a period of four months (eight reported occurrences in January 2015).
<p>Criterion 3.5.7</p> <p>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</p>	CI	The infection control nurse collates data about infections by category and resident area each month, comparing data with previous months and actively analysing data. Trend analysis and techniques to improve trends are discussed at facility meetings and often result in toolbox talks or staff education. Analysed data completed monthly is comprehensive.	The infection control nurse analyses all infection data with the support of the clinical manager and is active in engaging in research to identify innovative measures to reduce infection rates when a trend is identified. An example is of the identification of recurrent blepharitis rates in 2015. Following research, the infection control nurse identified that baby shampoo eyewashes

<p>a timely manner.</p>			<p>could reduce the risk in identified residents. Following discussions with the GP, a plan was developed. The registered nurses, GP and infection control nurses identified criteria for the use of the washes and a training package was developed and provided for staff. The practices of staff are witnessed and monitored frequently by the infection control nurse. As a result of the intervention, the blepharitis rate has reduced, particularly for residents with previously recurrent infection.</p>
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End of the report.