Radius Residential Care Limited - Radius Lexham Park

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 Lexham Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 June 2017 End date: 15 June 2017

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: 62

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Radius Lexham Park is owned and operated by Radius Residential Care Limited. The service provides care for up to 62 residents requiring rest home or hospital (geriatric and medical) level care. On the day of the audit, there were 62 residents. A registered nurse, with experience in aged care management manages the service. A Radius regional manager and a clinical nurse manager support her. Residents and relatives interviewed spoke positively about the service provided.

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

The service has exceeded the standard around supporting bereaved families, staff and residents following the death of a resident, advocacy, outdoor areas and the food service.

This audit has identified an area for improvement around staff training, amending care plans when needs change, assessment of pressure injuries and completion of monitoring forms.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code. Personal privacy and values of residents are respected. 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.		Some standards applicable to this service partially attained and of low risk.

Services are planned, coordinated, and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded. Corrective actions are implemented and evaluated where opportunities for improvements are identified. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff.

Ongoing education and training is in place, which includes in-service education and competency assessments. Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

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 medium or high risk and/or unattained and of low risk.

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

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

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

Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided.

Safe and appropriate environment

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

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms except one shared by a married couple are single occupancy and have either a shared or individual ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are lounge and dining areas in the facility. The internal areas can be ventilated and heated. The outdoor areas provide seating and shade. Cleaning and maintenance staff are providing appropriate services.

There is an approved evacuation scheme and emergency supplies for three litres of water per day per resident, for three days. There is a minimum of one first aid trained staff member on every shift.

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.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enabler. During the audit, there was one resident using a restraint and two residents using enablers. Staff regularly receive training around restraint minimisation and enablers.

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. An outbreak in March 2017 was contained to one staff member and four residents.

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	45	0	2	1	0	0
Criteria	4	94	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Lexham Park 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 twelve care staff (six healthcare assistants (HCA's), three registered nurses (RN), one enrolled nurse and two activities coordinators) confirmed their understanding of the Code. Eight residents (five rest home and three hospital) and four relatives (three hospital and one rest home) interviewed confirmed that staff respect privacy and support residents in making choices.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give	FA	Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Eight of eight resident files sampled, including three rest home level (one under carer support) and five from the hospital including one resident under a palliative care contract, one on a young persons with

informed consent.		disabilities contract and one resident under the primary care inpatient service contract, had a signed admission agreement and consents.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	CI	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Advocacy pamphlets and information is available throughout the facility. An advocate/support person is readily available and made known to residents and relatives at the quarterly resident meetings. 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. The service has exceeded the required standard around ensuring residents have access to an advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents 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. Residents are supported and encouraged to remain involved in the community. 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. There are several ways Lexham Park support ongoing access to community services, for example, visits to the RSA and a variety of community activities.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed 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 the requirements determined by the Health and Disability Commissioner (HDC). Ten complaints were received in 2016 and three complaints 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 management (triangle of support) 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.	CI	A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. 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. The service has exceeded the required standard around the process followed after the death of a resident.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The Māori health plan for the organisation references local Māori healthcare providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged. Māori consultation is available through the documented iwi links (Otawhiwhi Marae) and Māori staff who are employed by the service. During the audit, there were no residents that identified as Māori.
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,	FA	An initial care-planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs.

cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	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 district health board (DHB). The service makes use of Apple TV to view up to the minute topics to help enhance learning and retention of knowledge for staff, whilst also making the training interesting, fun and relevant. The Lexham Park 2017 business plan has been discussed with staff and they are encouraged to have input in assisting the service in moving forward. 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 one RN on the afternoon and night shifts with an additional RN on the morning shift. A physiotherapist is available nine hours per week. Registered nurses and HCAs were described by residents and family as being caring.
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 fifteen 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	Lexham Park is part of the Radius Residential Care Group. The service provides care for up to 62 residents requiring hospital (including one acute primary care inpatient service bed) and rest home level care. There are 50 dual-purpose beds. On the day of the audit there were 62 residents in total, 22 residents receiving rest home level care and 40 receiving hospital level care including three younger persons with disabilities (YPD), two residents on a palliative care contract, one resident on carer support and one resident on an acute primary care inpatient service contract. The facility manager is a RN and has been in the role since 2008 and has over 17 years' experience in

		aged care management. She is supported by a clinical nurse manager, who has been in the position for 10 months and has been at Lexham Park for three years. The regional manager supports the facility manager in the management role and was present during the days of the audit. The facility manager has completed more than eight hours of training annually relating to the management of a hospital. The Lexham Park 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 manager reports monthly to the regional manager on a range of operational matters in relation to Lexham Park including strategic and operational issues, incidents and accidents, complaints and health and safety.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The clinical nurse 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.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the managers reflected staff involvement in quality and risk management processes. Resident meetings are bi-monthly. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. 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 residents with medical needs and the Health and Disability Services (Safety) Act 2001. The clinical nurse 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 established processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflected actions

		being implemented and signed off when completed. Health and safety policies are implemented and monitored by the health and safety committee. The health and safety representative (administrator) interviewed confirmed her understanding of health and safety processes including recent law changes. She completed the external health and safety training in May 2017. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Radius has achieved tertiary level ACC Workplace Safety Management Practice. Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. A review of fifteen 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. An outbreak in March 2017 was appropriately notified and two unstageable pressure injuries were notified to HealthCERT during the audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Human resources policies include recruitment, selection, orientation and staff training and development. Nine staff files reviewed (one clinical nurse manager, two registered nurses (RNs), three healthcare assistants (HCAs), one kitchen manager, one administrator and one activities coordinator) 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. 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 that exceeds eight hours annually but attendance has been low. Staff, particularly registered staff have appropriate competencies and training to meet the medical needs of residents in the primary options acute inpatient bed and those on palliative care contracts. All staff participate in education relevant to physical disability and young people with physical 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. Two of seven RNs have completed their InterRAI training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A policy is in place for determining staffing levels and skills mix for safe service delivery. There is a full-time facility manager and clinical nurse manager who work from Monday to Friday. There is a minimum of one RN on site at any time. When residents with palliative care or medical needs are in the facility at least one registered nurse on duty has competencies relating to the required cares. There are two RNs on duty on the morning shift, one on the afternoon shift and one on the night shift in the hospital area. In the rest home, there is one enrolled nurse (EN) on the morning shift, the RNs from the hospital cover the afternoon and night shifts in the rest home area. The entire facility is on one level and the rest home and hospital areas are in close proximity. The RNs are supported by adequate numbers of HCAs. In the rest home area (22 rest home and eight hospital residents), there are four HCAs on duty on the morning shift, four HCAs on the afternoon shift and one HCA on the night shift. In the hospital area (32 hospital residents), there are seven HCAs on duty on the morning shift (including one floating HCA), six HCAs on the afternoon shift and one HCA on the night shift. 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. Staffing can be increased if resident acuity is high. Residents and family members interviewed report there are sufficient staff numbers.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for	FA	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager or clinical nurse manager screen 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

services has been identified.		service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. The acute primary inpatient resident has a plan documented to return home when the medical issue is resolved. The carer support resident will be returning to the care of their primary caregiver. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Registered nurses and enrolled nurses are responsible for the administration of medications and they complete an annual medication competency and attend medication education annually. Medication prescribed is signed as administered on the pharmacy generated singing chart. The facility uses a robotic sachet system for regular medications and blister packs for 'as required' medications. The RN on duty reconciles the delivery and documents this on the signing sheet. There were two self-medicating residents on the day of audit and both had current competency assessments around self-administration of 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 16 medication charts reviewed had photo identification and allergy status identified.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The service employs a Monday to Friday qualified kitchen manager and a second cook for every second weekend. Kitchenhands support the cooks. All staff have attended food safety hygiene training and chemical safety. There is a fully functional kitchen and all meals and baking are 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 rest home dining room, from the kitchen and they are delivered in a hotbox to the second dining area. A resident nutritional profile is developed for each resident on admission and is provided to the kitchen staff. The kitchen manager (interviewed) is notified of any dietary changes. Resident likes, dislikes, dietary preferences, modified and special diets are

		accommodated. An example includes the evening meal prior to audit day when four different meals were provided to cater to likes and dislikes. There is special equipment available for residents if required. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. All food is stored appropriately and dated. Residents interviewed were satisfied with the quality and variety of food served. The service has exceeded the required standard around meeting the individual choices and the dining experience for residents.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. In files sampled appropriate assessment tools (paper based for some residents and InterRAI for some) were completed and assessments were reviewed at least six monthly for long-term residents 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, but were not always updated when needs changed (link 1.3.8.3).
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 (link 1.3.8.3 regarding care plan updates when needs changed). 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	PA Moderate	Registered nurses (RNs, including the clinical nurse manager), enrolled nurses and healthcare assistants follow care plans and report progress against the care plan each shift. The resident on carer support and

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		the resident on the acute primary inpatient contract, had a short stay care plan that documented needs. For the acute primary inpatient resident, a short-term care plan documented interventions regarding the reason for admission and this had been regularly updated. When a resident's condition changes, the RN initiates a GP or nurse specialist consultation or referral, for example to the district nurse. If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Wound assessment, monitoring and wound management plans are in place for 12 residents with 19 wounds which are being appropriately managed. There were eight pressure injuries (seven facility-acquired and one community acquired) on the day of audit. Six of these had been correctly assessed. There is district nurse involvement in the management of the unstageable pressure injuries and chronic ulcers. Care plan interventions including intentional rounding and one of two turning charts sampled demonstrated interventions to meet resident's needs. Food and fluid charts were not appropriately completed.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	A part time diversional therapist and two activities coordinators (one 35 hours per week and one 22 hours per week) are employed to provide the activities programme. They have access to regional DT networks and support from the facility manager and from within the organisation. There are volunteers involved in the activity programme including entertainers, church groups, RSA visits and one-on-one time with residents. Exercise sessions are provided in a variety of forms to maintain interest and physical well-being for all groups of residents. The programme has allocated one-on-one time for hospital residents and for those who choose not to participate in the group activities. Activities and entertainment occur in the main lounge and the smaller lounge. Group activities reflect ordinary patterns of life such as baking, library books, board games, bowls, current affairs and arts and crafts. Outings into the community, to concerts and places of interest are planned. Special events are celebrated. In 2016 the activities staff identified that attendance of men at the activities programme was not as high as they wished and that many of the women no longer had the dexterity to participate in craft and other similar activities. Resident feedback was sought and a men's group and a women's group were formed. Both groups have had regular guest speakers of interest to the residents and each have been on regular outings to places of interest to the members of the group. Examples include the men's group visiting the men's shed, a car restoration facility, an alpaca farm and the Waihi beach hop. The women s activities have included pamper sessions and high teas.

		All long-term resident files sampled had a recent activity plan within the care plan and this was 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.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	The registered nurses or enrolled nurses with a registered nurse check and sign off, and evaluate all initial care plans within three weeks of admission. In six of eight files (two residents were short term) reviewed, the long-term care plan was evaluated at least six-monthly or earlier if there is a change in health status. There is at least a three-monthly review by the GP. Not all changes in health status were documented. Files reviewed demonstrated that short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing. Where progress is different from expected, the service does not always respond by initiating changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed and the resident reassessed. Examples of close liaison with dietitians, physiotherapist, mental health staff and social workers were sighted in resident files reviewed.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were stored safely throughout the facility. Safety datasheets are available. The two sluice rooms (one each wing) have personal protective clothing readily available.

Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness that expires 21 October 2017. The building has several alcoves and lounge areas. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Essential contractors are available 24 hours. Hot water temperatures are monitored monthly and are maintained between 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. Residents have access to external areas that have seating and shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. The service has exceeded the required standard around the outdoor facilities provided for residents and families.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All rooms have either a single ensuite (32 rooms) or a shared ensuite between two rooms (30 rooms). Additionally, there are communal toilets and shower/bathing areas for residents. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids, including those required by hospital level residents. Residents are encouraged to personalise their bedrooms. Electric beds and ultra-low beds are used for hospital residents as assessed.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age	FA	There is a large main dining room adjacent to the kitchen for more able residents. A smaller dining/lounge space is available for those residents who require more assistance. Two large separate lounge areas are available. There is safe and easy access to communal areas.

appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry including personal clothing is laundered on-site by dedicated laundry staff. The laundry has defined dirty/clean areas. The two laundry/cleaning staff interviewed reported they have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility. The cleaners' trolleys are well equipped and stored in sluice rooms when not in use. Residents and relatives interviewed were satisfied with the laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an 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 24 January 2017. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and ongoing training. Civil defence supplies are checked monthly. There is sufficient water stored to ensure 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 under floor heating and free-standing oil heaters. The facility is well ventilated when required. All rooms have external windows that open allowing plenty of natural sunlight.
Standard 3.1: Infection control	FA	Radius Lexham Park has an established infection control programme. The infection control programme,

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.		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 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 Lexham Park 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 have good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are Radius infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated.
Standard 3.4: Education The organisation provides relevant education on infection	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is

control to all service providers, support staff, and consumers.		appropriate to their needs and this is documented in medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in Radius' infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually, and is provided to Radius head office. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality meetings and staff meetings and plans and interventions resulting from surveillance create improvements in a way that exceeds the required standard. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the acting facility manager. An outbreak in March 2017 was appropriately managed.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. During the audit, there was one resident using a restraint (bedrail) and two residents using an enabler (lap belt and bedrail). Staff training is in place around restraint minimisation and enablers.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical nurse manager) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.
Standard 2.2.2: Assessment Services shall ensure rigorous	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. The restraint coordinator in partnership with the RNs, general practitioner (GP), resident and their

assessment of consumers is undertaken, where indicated, in relation to use of restraint.		family/whānau, undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. One hospital level resident where restraint (bedrail) was in use and two hospital level residents using an enabler (lap belt and bedrail) files were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident and family and the GP. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in the resident file where restraint was being used.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly as part of the restraint committee meeting. A review of three resident files identified that evaluations are up-to-date.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint minimisation programme is discussed and reviewed at the monthly restraint meetings, attended by the restraint coordinator (clinical nurse manager), RNs and HCAs. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme and staff training.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Radius Lexham Park has an established training programme. The service has worked to improve staff attendance including questionnaires and competency assessments for staff who do not attend training sessions. Staff training around skin integrity and pressure injury management had low attendance (link 1.3.6.1). The service has had difficulty accessing InterRAI training for staff.	Only seven staff have completed training around skin integrity and pressure injury prevention.	Ensure all staff have received training around maintaining skin integrity and reducing the incidence of pressure injuries. 180 days
Criterion 1.3.6.1 The provision of services and/or	PA Moderate	Care staff including registered nurses, could describe appropriate interventions to minimise the risk of pressure injuries but pressure injuries were not all accurately assessed. Residents, including those on food and fluid charts were seen to be offered and assisted with	(i) One resident had two unstageable pressure injuries incorrectly graded as stage 1.	(i) Ensure staff are trained in the assessment of pressure

interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.		meals and fluids but this was not accurately recorded. The HCAs reported that residents who require regular turns are repositioned regularly but not all turning charts had been accurately completed.	Registered staff interviewed were not aware of what an unstageable pressure injury was. (ii) Two fluid balance charts and one turning chart sampled had not been accurately completed.	injuries and that these are correctly assessed. (ii) Ensure monitoring forms are accurately documented. 30 days
Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Low	Interviews with healthcare assistants and registered nurses demonstrated that when a resident's needs change this is communicated to all staff at handovers and that all residents are receiving appropriate care for their current needs. However, changes in needs are not always documented in the care plans.	Three of six long-term resident files sampled (one rest home and two hospital) had not been updated when resident needs had changed.	Ensure care plans reflect each resident's current needs. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.	CI	Residents and relatives interviewed stated that they have access to an advocate/support person, who understands their needs and has good knowledge of the facility. An advocate/support person is readily available and made known to residents and	In 2016 the service identified a need to improve the experience for residents and relatives accessing an advocate/support person. It was identified that while the Health and Disability advocacy service attended Lexham Park from time to time, residents and family members would have better access to advocacy if a resident or family advocate was appointed. Family members and residents were asked to self-nominate, and a family member was identified as the resident and family contact. This person has met with the Health and Disability advocate for the area and a memorandum of understanding between the two parties has been signed. Residents and family members have been informed about the advocate and the advocate attends all resident and family interviews. They are also provided with a copy of the annual resident and family survey to ensure a transparent process. Annual client satisfaction survey results and statistics are compared and analysed against previous year’s results. Results and outcomes of the client satisfaction survey completed in 2016 showed that 90% of respondents reported either very satisfied or satisfied how concerns are managed compared to 80% in 2015.

		relatives at the quarterly resident meetings.	
Criterion 1.1.3.2 Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.	CI	The service provides services that are individualised and focus on dignity and respect. Following feedback from residents, staff and families around the difficult time when a resident dies, a number of initiatives improved this process and exceed the required standard.	Over late 2015 personal communication with families and residents, staff and the management team identified that when a resident died this was respectfully acknowledged but the body was often removed without residents and families (of other residents, not the deceased resident) knowing. Staff were uncertain when rooms had been blessed and were also grieving and families and residents were often not able to attend funerals (due to health, private funerals or other commitments). A project was established to manage the after-death process of a resident in a manner that was more respectful to the staff, residents and family members of residents who had grown close to the resident. The project involved every resident being escorted from the facility through the main doors by a senior staff member and the funeral director and a guard of honour formation at the front door by staff and residents to pay respect and farewell the resident from the facility. Candles are lit, music played and flowers are picked and placed on the resident as they pass through the guard of honour. Staff farewell the resident as the hearse leaves the premises. An annual 'All Souls' Day, last marked early in November 2016 where all those who had lost a member of family or friend during the past twelve months are invited to attend an afternoon remembrance service. At the service a family member, friend or staff member release a helium balloon for each individual who passed during the previous 12 months. A total of around 100 people attended the service. Compliments and feedback from families after a passing is overwhelmingly positive. Cards and tributes to the staff are frequent, and these are posted in the staff room and relayed at staff forums. Funeral directors are positive about the way in which the facility pays its last respects allowing staff, family and other residents to be involved in saying farewell openly. The consistent positive feedback supports continuance of this practice. Annual client satisfaction survey results and statistics are compared and analysed against previous year's results. Results of the client satisfaction survey completed in 2016 showed that 95% of respondents reported either very satisfied or satisfied around dignity and respect provided compared to 90% in 2015.
Criterion 1.3.13.2 Consumers who have additional or	CI	The kitchen manager and kitchen staff are constantly reviewing the menu to ensure	In the 2016 food satisfaction survey, satisfaction was high but the kitchen manager and management determined that they could do more to cater to resident preferences and increase individual enjoyment of meals. The kitchen manager attends all resident meetings to obtain feedback about specific meals and overall feedback. Because of this she has developed an understanding of residents 'favourite' foods rather than just likes or dislikes and she tries to ensure these are provided to individual residents. This was demonstrated on the day of the audit when four different meals were served at lunch time to cater to

modified nutritional requirements or special diets have these needs met.		residents individual needs and preferences are catered for.	residents' preferences and one resident reported sometimes getting bacon and eggs for breakfast which is a special favourite of theirs. Additionally, to improve the meal experience the service developed a previous small lounge into a tucked-away café that makes a statement of the desire of the service to adopt the 'feel of modern with a slice of traditional, and definitely groovy'. Opening a space previously occupied by a family lounge they have incorporated a kitchen area that is accessible both internally and externally with ranch doors on to a patio with café style seating. A small lounge area within the café was retained to allow patrons to watch TV and relax. A good size kitchen table with chairs installed to allow for social gatherings outside of the usual dinning space. A Nespresso was installed allowing patrons to make café quality coffee, along with porcelain tea pots for tea making tea. During the audit, several residents and families utilised this space to cook hot toast, heat meals bought by visitors for residents or make a Nespresso coffee. Residents and relative's overall satisfaction with the food service has continued to increase year on year since 2015.
Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.	CI	Radius Lexham park has had an ongoing project to improve residents access to and enjoyment of outdoor areas.	Radius Lexham Park has continually strived to increase residents use and enjoyment of the outdoor areas. Improvement since the last audit include increasing the hours of the gardener from four hours per week to 12 hours per week to maintain and improve the gardens. The gardener interacts with residents to find out what they want and where possible implements this. One comment in the 2016 resident satisfaction survey was about wishing to see more garden outside their room. To achieve this for all residents the men's club has joined with the local 'Men in their Sheds' group. An article was written in the Katikati advertiser about this. The two groups have worked together to build step ladder type planter boxes which enable residents to garden safely and provide more gardens for residents to see and enjoy. This has resulted in a 10% increase in satisfaction with walkways and grounds between the 2016 and 2017 resident and relative satisfaction surveys.

End of the report.