

# Radius Residential Care Limited - Radius Kensington

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Radius Residential Care Limited
<b>Premises audited:</b>	Radius Kensington
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
<b>Dates of audit:</b>	Start date: 1 August 2018 End date: 2 August 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	79

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Radius Kensington is owned and operated by Radius Residential Care Limited. The service provides care for up to 97 residents requiring rest home, hospital (geriatric and medical), residential physical disability and dementia level of care. On the day of the audit there were 79 residents.

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

The service is managed by a facility manager/registered nurse who has experience in aged care management. She is supported by a Radius regional manager and a clinical nurse manager. Residents, relatives and the GP interviewed spoke positively about the service provided at Kensington.

This audit has identified an area for improvement around resuscitation documentation. The service has been awarded a continuous improvement around meeting the recreational preferences for the younger persons who reside at the facility.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review process. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed, verified ongoing involvement with community.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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A facility manager and clinical nurse manager are responsible for the day-to-day operations. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities, including Radius key performance indicators, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings are held bi-monthly and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An education and training programme has been implemented with a current plan in place. An orientation programme is in place for

new staff. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care. Residents and families reported 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.

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

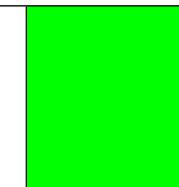
Entry to the service is managed primarily by the facility manager/registered nurse or clinical nurse manager. There is service information available on the three service levels of care. Initial assessments are completed by a registered nurse. Care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans and worklogs (developed on the electronic resident system) 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. The general practitioner reviews residents at least three monthly. There is allied health professional involvement in the care of the residents.

The activity programme is varied and interesting and includes outings, entertainment and links with the community. Each resident has an individual leisure care plan. The rest home and hospital have an integrated programme. There are activities that meet the younger persons. The activities in the dementia unit are flexible and meaningful.

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 prescribed and administered in line with appropriate guidelines and regulations.

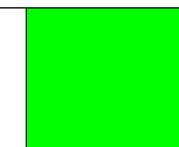
Meals and baking are prepared on-site by trained cooks and kitchenhands. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. There are nutritious snacks available 24 hours.

## 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 building warrant of fitness. There is a reactive and maintenance plan. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy with a mix of ensembles and communal toilet/shower rooms. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are lounge and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor courtyards for each area 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. There is at least one staff member on duty at all times with a first aid certificate.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. At the time of the audit there were two residents using restraints and eleven residents using an enabler. Staff receive regular education and training on restraint minimisation.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

There are infection control management systems in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. The infection control coordinator has attended external education. 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. 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.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	48	0	1	0	0	0
<b>Criteria</b>	1	99	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Discussions with eleven care staff, including six healthcare assistants (HCA), two registered nurses (RN) and three activities coordinators confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Eight residents (five rest home and three hospital) and five relatives (three rest home, one hospital and one dementia care) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice. Staff receive training on the Code, last occurring in June 2018.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low	Informed consent processes are discussed with residents and families on admission. Consent forms, advanced directives and copies of enduring power of attorney (EPOA) where applicable, were seen on each individual electronic resident database (e-case) in the nine resident files reviewed, which included three rest home (including one younger person with a physical disability and one respite care) four hospital (including one younger person under long-term chronic health condition and one resident under ACC funding) and two dementia level of care residents. Advanced directives covered end of life wishes and resuscitation status. Not all resuscitation status had been signed appropriately. There is evidence of general practitioner discussion with family regarding resuscitation, as evidenced in the e-case progress notes.

		<p>Healthcare assistants and registered nurses (RN) 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>All nine resident files reviewed had a signed admission agreement.</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 are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (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. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, (e.g., attending cafés, and restaurants). Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Radius Kensington has a number of younger people including residents on YPD contracts. These residents are engaged in a range of diverse community activities including (but not limited to) health and wellness, social groups and community outings. 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. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility. There is a complaint register that includes relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings. There have been eight complaints made in 2017 and eleven received in 2018 year to date. The complaints reviewed included follow-up meetings and letters, resolutions were completed within the required timeframes as determined by the Health and Disability Commissioner.</p> <p>One of the complaints received in 2017 was made through the district health board (DHB) in November 2017, the complaint was investigated, followed up and closed off by the DHB in June 2018. The complaint was reopened and was made through the Health &amp; Disability Commissioner (HDC) in June 2018. A correction action plan has been implemented and investigated. Kensington responded</p>

		to the HDC letter in July 2018 and at the time of the audit were awaiting a response from HDC.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	The service provides information to residents that includes the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code of Rights. Bi-monthly resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	Staff interviewed could describe the procedures for maintaining confidentiality of resident records, residents' privacy and dignity. The 2018 satisfaction survey identified 92% of residents were happy with privacy. Contact details of spiritual/religious advisors are available. Staff education and training on abuse and neglect has been provided, last occurring in July 2018. Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	Kensington has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of audit, there were 12 residents who identified as Māori. Four Māori resident files were reviewed and included a Māori health plan. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Māori consultation is available through a local Māori Kaumātua who visits on a weekly basis.
<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/able are invited to be involved. Individual beliefs or values are further 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. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values. The 2018 satisfaction survey identified 96% outcome for cultural/spiritual needs being met.

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities, and staff sign a copy on employment. The staff/quality meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provides guidelines and mentoring for specific situations. Interviews with the facility manager, clinical nurse manager and RNs confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The Radius quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. Policies and procedures have been reviewed and updated at organisational level and are available to staff. Staff meetings and residents' meetings have been conducted. Residents and relatives interviewed spoke positively about the care and support provided. Staff had a sound understanding of principles of aged care and stated that they feel supported by the facility manager, clinical nurse manager and nursing staff. There are implemented competencies for HCAs and RNs. There are clear ethical and professional standards and boundaries within job descriptions.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the health status of residents and fifteen incidents/accidents sampled confirmed this. Resident/relative meetings are held bi-monthly. The facility manager and clinical nurse manager have an open-door policy. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made 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 Kensington is part of the Radius Residential Care group. The service currently provides rest home, hospital and dementia level care and residential disability (physical) for up to 97 residents. On the day of the audit there were 79 residents, 18 rest home, 46 hospital and 15 dementia level residents. This includes one rest home and three hospital residents on younger persons with disabilities (YPD) contracts, one hospital resident on a long-term support chronic health condition (LTS-CHC) contract and four hospital residents funded by the ACC. The service also has a post-acute convalescent care (PACC) contract, however there were no residents on this contract at the time of the audit. All rest home and hospital beds are dual-purpose. All other residents were under the aged related residential care (ARRC) contract.</p> <p>The Radius Kensington business plan 1 April 2018 to 31 March 2019 is linked to the Radius</p>

		<p>Residential Care group strategies and business plan targets. The mission statement is included in information given to new residents. An organisational chart is in place. Quarterly reviews are undertaken to report on achievements towards meeting business goals.</p> <p>The facility manager has been in the role for five years. She is supported by a clinical nurse manager, who has been in the role since April 2018 and an office manager who has been in the role for seven years. The regional manager also supports the facility manager in the management role and was present during the days of the audit.</p> <p>The facility manager has maintained more than 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>	FA	<p>In the absence of the facility manager, the clinical nurse manager is in charge, with support from the regional manager and care staff.</p>
<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>There is an organisational business plan that includes quality goals and risk management plans for Kensington. Quality and risk performance is reported across facility meetings and to the regional manager. The facility manager advised that she is responsible for providing oversight of the quality programme. There are monthly staff/quality meetings where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff. Required actions and resolutions from facility meetings are documented. Resident/relative meetings are monthly. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The overall service result for the resident/relative satisfaction survey completed in March 2018 was at 96%. A corrective action plan was developed and completed in April 2018 around food service and activities. Surveys include young people with disabilities around issues relevant to this group.</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. There are policies and procedures appropriate for service delivery including the specific needs of younger people. The clinical managers group, with input from facility staff, reviews the services policies at national level every two years. Clinical guidelines are in place to assist care staff. The quality</p>

		<p>monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions are evaluated and signed off when completed.</p> <p>Restraint and enabler use is reviewed at the monthly staff/quality meeting. Health and safety policies are implemented and monitored by the health and safety committee. The health and safety representative (office manager) interviewed, confirmed their understanding of health and safety processes. She has completed external health and safety stage three training. Risk management, hazard control and emergency policies and procedures are in place. Hazard identification forms and an up-to-date hazard register (last reviewed in January 2018) are in place. Radius has achieved tertiary level ACC Workplace Safety Management Practice. Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions.</p>
<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. Incidents are included in the Radius key performance indicators (KPI). There is a discussion of incidents/accidents at the monthly staff/quality meetings including actions to minimise recurrence. A review of fifteen incident/accident forms from July 2018, identified that forms are fully completed and include follow-up by a RN. Neurological observations were completed for eight reviewed unwitnessed falls or suspected injury to the head. Discussions with the facility manager and regional manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 notification made since the last audit for an unstageable pressure injury in December 2017. A gastro outbreak in December 2017 was also notified to the public health authorities.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Nine staff files reviewed (one facility manager, one clinical nurse manager, two RNs, three HCAs, one activities coordinator and one cook) include a 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. Registered nurses are supported to maintain their professional competency. The orientation programme provides new staff with relevant information for safe work practice. Staff are required to complete written core competencies during their induction.</p>

		<p>These competencies are repeated annually.</p> <p>There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. All staff participate in continuing education relevant to physical disability and young people with physical disabilities, including sessions on privacy/dignity, spirituality/counselling and social media. Three of twelve RNs have completed their interRAI training with another one currently in progress of completing. Registered nurses are supported to maintain their professional competency. There are sixteen HCAs who work in the dementia unit. Eleven HCAs have completed the dementia standards and five HCAs are in progress of completing. The five HCAs in progress of completing have commenced work within the last 12 months.</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. Residents and family members interviewed reported there are sufficient staff numbers. There is a full-time facility manager and clinical nurse manager who work from Monday to Friday.</p> <p>The hospital/rest home beds are divided into three units: unit A has 24 residents (four rest home and 20 hospital) and unit C has 23 residents (five rest home and 18 hospital). There are three RNs on duty on the morning shift (one short shift), two on the afternoon shift and one on the night shift in the rest home/hospital area. The RNs are supported by adequate numbers of HCAs. There are three HCAs on duty on the morning and afternoon shifts and one on the night shift in both unit's A and C. Unit B has 17 residents (nine rest home and eight hospital), there are two HCAs on duty in both the morning and afternoon shifts. There is an additional HCA floater in the morning and afternoon shift available to assist where needed.</p> <p>In the dementia unit (15 dementia residents), there are two HCAs on duty on the morning and afternoon shifts and one 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. The RNs on duty in the rest home/hospital area also cover the dementia unit. In the dementia unit, staff stated that overall, the staffing levels are satisfactory and that the managers provide good support.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and</p>	FA	<p>The resident files sampled 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 by being held in a locked office.</p>

accessible when required.		
<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 admission policies and processes in place. Residents receive a welcome pack outlining services able to be provided, the admission process and entry to the service. The welcome pack includes specific information on the secure dementia care unit. The facility manager/registered nurse or clinical nurse 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 facility manager. The admission agreement aligns with the requirements of the ARCC. Exclusions from the service are included in the admission agreement.</p>
<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. Residents in hospital or on social leave is identified and monitored through the e-case resident database.</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. Registered nurses and senior HCAs administer medications and have completed medication competencies and medication education. Medication administration was observed in the hospital unit and administration practice was compliant against the administration policy. Medications are delivered fortnightly in robotic rolls and these are checked by the RN against the medication chart. There is one rest home resident self-medicating who has a current self-medication competency. There is one medication room with trolleys for each unit. All medications are stored safely. The medication fridge is monitored daily, and all temperatures were within the acceptable range. The hospital bulk supply order is checked for expiry dates weekly. The eye drops, and creams/ointments have been dated on opening.</p> <p>Eighteen medication charts (paper-based) were reviewed (eight hospital, six rest home and four dementia care) met prescribing requirements. The GP has reviewed the medications at least three monthly. All medication charts had photo identification and allergy status noted.</p>
Standard 1.3.13: Nutrition, Safe	FA	There is a fully functional main kitchen where all food and baking are prepared and cooked. The main

<p><b>Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>cook is supported by morning and afternoon kitchenhands. The four-weekly menu has been reviewed by the Radius dietitian, May 2018. The main meal is at 5.00 pm. Meals are plated and transported to the kitchenettes (rest home, hospital and dementia unit) in hot boxes. The cook accommodates meals for residents with dislikes, with alternative foods offered. Special dietary requirements are accommodated including pureed meals, vegetarian, gluten free and diabetic desserts. There is special equipment available for residents if required. A resident dietary profile is developed for each resident on admission and provided to the kitchen staff. The chef is notified of any changes to residents' dietary requirements. There are Complian drinks and nutritious snacks available 24 hours.</p> <p>The food control plan expires 24 August 2019. End-cooked temperatures and hot/cold box temperatures are monitored. The temperatures of all refrigerators, freezers, inward goods and chiller are monitored and recorded. The chemical provider checks and monitors the performance of the dishwasher. All food is stored appropriately and dated. A daily and monthly cleaning schedule is maintained.</p> <p>The residents have the opportunity to provide feedback on the food services at their meetings and through surveys. Residents and the family members interviewed, commented positively about the quality and variety of food served.</p>
<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Information received from hospital discharge, homecare interRAI assessments and GP medical notes are used to develop the initial interim care plan within 24 hours. Appropriate assessment tools have been completed on the e-case and reviewed at least six monthly or when there was a change to a resident's health condition in files reviewed. Electronic care plans are developed on the outcomes of these assessments. InterRAI assessments had been completed for new residents within 21 days and are utilised as part of the six-monthly evaluation of care plans.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long-term care plans reviewed described the support required to meet the resident's goals as identified by the ongoing assessment process, and nursing interventions were documented to meet the resident needs/supports. Twenty-four-hour behaviours plans were in place for dementia care residents. A care summary was available to care staff on the e-case outlining cares and individual needs. Allied health involvement was linked to the long-term care plans. Residents and their family/whānau confirmed they are involved in the care planning and review process. The electronic progress notes evidence resident/relative involvement in care planning and reviews. Short-term care plans are in use for changes in health status and easily accessed on the electronic e-case system. Care requirements are generated into the care staff worklog. Staff interviewed reported they found the plans easy to follow and readily available.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Registered nurses (RNs) and HCAs follow the detailed and regularly updated care plans and report progress against the care requirements each shift. If a resident's health status changes the RN initiates a GP or nurse specialist review. Relatives interviewed stated they are contacted for any changes in the resident's health. Conversations with relatives is documented within the electronic progress notes.</p> <p>Staff have access to sufficient medical supplies including dressings. Wound assessment and care plans, wound review plans and evaluation notes were in place for residents with wounds. Photographs identified size and healing progress. There were no residents with pressure injuries. One resident with a healed stage one had two hourly pressure care monitoring in place. RNs (interviewed) have access to specialist nursing wound care management advice through the DHB. Any residents with non-healing wounds for four weeks are referred to the wound nurse specialist.</p> <p>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>Electronic monitoring forms are completed and reviewed for example turning charts, food and fluid charts, blood pressure, weight charts, behaviour charts, blood sugar levels and neurological observations. Short-term care plans sighted had been reviewed regularly and either resolved or if ongoing updated on the relevant care plan.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements</p>	<p>CI</p>	<p>There are three activity coordinators employed to implement the activity programme across the services. The rest home/hospital programme is integrated and occurs in several lounges, library area and dining rooms Monday to Friday from 10.00 am to 3.30 pm. The activity hours are flexible around weekend events. The activity coordinator for the dementia unit has completed the dementia unit</p>

<p>are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>standards and activities are provided seven days a week from 9.45 am to 4.30 pm. Care staff are involved in resident activities as part of their role. All activity coordinators have a current first aid certificate.</p> <p>The rest home and hospital programme are integrated and includes newspaper discussion and current events, exercise groups, music, bell ringing, board games, bowls, arts and crafts, coffee groups, men's group, movies and happy hours. One-on-one time is spent with residents who choose not or are unable to participate in group activities. Small group activities were observed for higher acuity residents in the observation lounge under staff supervision. Multi-sensory group activities include one-on-one hand massages, chats and reading. There are at least three activity groups happening at one time giving residents a choice of activity to attend.</p> <p>The dementia unit residents have a flexible programme, which includes crafts and art, music therapy, bowls, games and one-on-one therapy. Each day there are meaningful activities available for residents to participate in, such as cleaning tables, picking flowers, sweeping, feeding birds, watering plants, reminiscing and walks around the garden. Residents are invited to attend entertainment and other events in the rest home/hospital as appropriate and under supervision. Pet therapy visitors visit all areas.</p> <p>Community visitors includes church services, entertainers, weekly pre-schoolers and high school students and pet therapy. The activity programme for dementia care residents is flexible and focused on meaningful activities, small group activities and one-on-one time. There are regular van rides and outings to community groups such as stroke club, Cossie club, shopping and cafes. The van has wheelchair access.</p> <p>The service has five residents under the age of 65 years. This group of residents meet regularly with the activity coordinator to plan and coordinate their activities/outings. The service has successfully met the recreational activities for the younger person.</p> <p>All resident files reviewed have an individual recreational assessment and activity plan on e-case that is evaluated at least six monthly. Residents and families interviewed commented positively on the activity programme. Residents have the opportunity to feedback on the activity programme through two monthly resident meetings.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial interim care plans are evaluated by the registered nurses within three weeks of admission. In the electronic files reviewed the long-term care plan was evaluated at least six-monthly for residents who had been at the service six months. There is at least a three-monthly review by the GP. Written evaluations identify if the resident/relative goals are met or unmet. There were case conference multidisciplinary notes on the electronic e-case system that evidenced relative/resident (as</p>

		appropriate) involvement in care plan evaluations.
<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>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on electronic resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs and responded to in a timely manner. Referrals and options for care were discussed with the family as evidenced in progress notes and e-case medical notes. The staff provided examples of where a resident's condition had changed, and the resident was reassessed for a higher level of care. Examples of close liaison with dietitians, physiotherapists, podiatrist, mental health service for the older person, assessment and rehabilitation team and Māori Health team were sighted in electronic resident files reviewed.</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>	FA	<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. Staff have completed chemical safety training.</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>	FA	<p>The single storey building has a current building warrant of fitness which expires 13 July 2019. There is a full-time maintenance person who actions repairs and maintenance requests through the e-case maintenance system. Monthly planned maintenance is completed as per the planned maintenance schedule and includes monthly hot water temperatures, internal and external building maintenance and clinical equipment checks (trolleys, walking frames and wheelchairs). The maintenance person is authorised to carry out electrical testing and tagging. There are essential contractors available 24 hours. Environmental improvements include continuing to refurbish resident rooms as they become vacant, new furniture and curtains, upgrade of nurses' station to accommodate e-case computer based system, new shelving in the kitchen storeroom, designated footpath in the driveway for residents to use safely and night lighting in the corridors.</p> <p>The facility has wide corridors for residents to mobilise safely using mobility aids. The external areas and courtyards are well landscaped. Residents have access to safely designed external areas that have seating and shade.</p> <p>The dementia unit has a spacious outdoor courtyard with a safe walking pathway that has entry/exit</p>

		<p>doors to and from the indoors. Seating and shade is provided.</p> <p>Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>All bedrooms have hand basins. There are a mix of rooms with ensuites and shared communal facilities. There are adequate numbers of toilets and shower rooms with vacant/in-use slide signs for privacy. Residents interviewed, confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident rooms are single. The rooms are of an appropriate size to allow for the safe use and manoeuvring of mobility aids and hoists. Resident rooms in the dementia care unit are spacious. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. Each unit has internal rooms and have doors that open out onto internal courtyards with sensory gardens.</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>There are several open plan dining and lounge areas including family rooms in the rest home, hospital and dementia unit. 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</p>	FA	<p>All linen and personal clothing is laundered on-site in a well-equipped laundry. The laundry operates from 7.00 am to 3.00 pm with designated laundry staff on duty. The laundry has a defined clean/dirty area with an entry and exit door. The laundry equipment is serviced six monthly. The chemical provider completes monthly quality control checks on the laundry and cleaning processes.</p>

<p>services appropriate to the setting in which the service is being provided.</p>		<p>The cleaners have access to a range of chemicals through a mixing system, cleaning equipment and protective clothing. Safety data sheets and product information is available. Cleaning trolleys are kept in locked areas when not in use.</p> <p>Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility and the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an emergency health management plan in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Kensington has an approved fire evacuation plan dated 16 November 2000. Fire evacuation drills occur six monthly with the last evacuation drill occurring on 13 June 2018. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (BBQ). The service has a backup system for emergency lighting and battery backup.</p> <p>Emergency food supplies sufficient for three days, are kept in the kitchen. Extra blankets are available. There are civil defence kits in the facility that are checked six monthly. There is sufficient water (water tank) stored to ensure for three litres per day for three days per resident. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitor's book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night.</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. Corridors and resident rooms can be individually adjusted. All rooms have external windows that open, allowing plenty of natural sunlight. Some rooms have external doors into courtyards.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	<p>FA</p>	<p>Radius Kensington has implemented the Radius infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPIs. The care manager (RN) is the designated infection control nurse with a job description that outlines the responsibility of the role and reporting requirements. The Radius infection control programme is</p>

infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		<p>reviewed annually at organisational level.</p> <p>Visitors are asked not to visit if they are unwell. Hand sanitisers were appropriately placed throughout the facility. Residents and staff are offered the annual influenza vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has completed a MOH on-line course. She has access to ongoing education and resource persons including Bug control newsletters/training, DHB infection control nurse, GP and public health.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. The infection control policies link to other documentation, uses references where appropriate and were last reviewed by Radius in September 2017. Input is sought from facilities when reviewing policies.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator ensures all new staff are orientated to infection control as part of the orientation programme and at least annually thereafter. There are infection control videos, competency questionnaires and hand hygiene audits completed by all staff. Topical tool box talks are also provided.</p> <p>Resident education is expected to occur as part of providing daily cares.</p>
Standard 3.5: Surveillance	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of</p>

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>infections and internal (process) monitoring is undertaken via the internal audit programme. Infections by type are collated monthly and reported to the combined quality, health and safety and infection control meetings. Data is analysed for trends and corrective actions. Meeting minutes and graphs are displayed for staff reading. Infection control is an agenda item on all facility meetings. The service submits data (monthly) to Radius head office where benchmarking is completed.</p> <p>There has been one gastroenteritis outbreak in December 2017. Case logs and the notification to the DHB health protection officer were sighted.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there were two residents using restraints (bed rails) and eleven residents using an enabler (all bed rails). All necessary documentation is available in relation to the restraints. Staff training has been provided around restraint minimisation in July 2018. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.</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 (RN) 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>The restraint coordinator, in partnership with the RNs, GP, resident and their family/whānau, undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Two residents' files where restraint was in use were reviewed, and contained completed assessments. The completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>

<p>Standard 2.2.3: Safe Restraint Use 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. Monitoring is documented on a specific restraint monitoring form and reflects the actual times monitoring occurred, evidenced in two resident files where restraint was being used.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). A review of two resident files identified that evaluations are up-to-date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint minimisation programme is discussed and reviewed at the monthly staff/quality meeting, attended by the restraint coordinator, RNs and HCAs. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme, and staff education and training. Six monthly internal audits of restraint practices are also completed.</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)
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	PA Low	The advanced directives included a resuscitation status that had been signed by the competent resident appropriately, and witnessed by the general practitioner. The resuscitation status for residents deemed to be incompetent had been signed inappropriately for three of nine files.	The resuscitation status had been signed by a relative for three residents (two hospital and one rest home) deemed to be incompetent to make a decision regarding resuscitation.	Ensure all resident resuscitation status is signed appropriately.  90 days

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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service has five younger people who are actively involved in providing suggestions for activities and outings of interest to the group. Individualised activity plans identify the younger persons recreational preferences, which have been accommodated. There is documented evidence of regular meetings, activities and photos of group events and outings.</p>	<p>The Younger Persons group was formed December 2016 and the residents were invited to their own Christmas lunch in the courtyard with foods of their choice. There are group outings for shopping and drives, such as a day trip to Raglan and scenic drives. There are monthly movie nights in the library lounge with a movie of their choice and snacks and nibbles of their choice. There are weekly get-togethers for quizzes, trivia and discussions/chats and sharing of information. The group enjoys regular barbeques in the courtyard. All meeting minutes and outings document good attendance whilst recognising and respecting individual choice to participate. There is very good feedback recorded in the meeting minutes and comments that the residents enjoy their activities with foods of their choice, as it acknowledges their different tastes in food, music and interests. Two younger people interviewed, confirmed their individual and group interests were met and they enjoyed the group activities. The service has been successful in providing activities that exceed the expectations of the younger persons.</p>

End of the report.