

Radius Residential Care Limited - Radius St Helena's Care Centre

Introduction

This report records the results of a Surveillance 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 St Helena's Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 January 2019 End date: 30 January 2019
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	51

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Radius St Helena's is owned and operated by Radius Residential Care Limited. The service provides care for up to 53 residents requiring rest home or hospital level of care. On the day of the audit there were 51 residents.

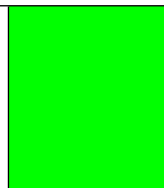
The service is managed by a facility manager/registered nurse who has been in the role six months and has experience in aged care. She is supported by a Radius regional manager and a clinical nurse manager. Residents, relatives and the GP interviewed spoke positively about the service provided at St Helena's.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and the general practitioner.

Three of three previous findings relating to training, interventions and evaluations have been addressed. There were no other areas identified for improvement at this surveillance audit.

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.

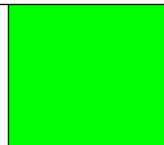


Standards applicable to this service fully attained.

There is open communication with residents and relatives which also includes open disclosure around incidents. There are three-monthly resident/relative meetings provide an opportunity for suggestions and feedback on the services provided at St Helena's. Information about the Code and related services is readily available to residents and families. Complaints processes are being implemented and complaints and concerns are managed and documented.

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.

A facility manager and clinical nurse manager are responsible for the day-to-day operations. They are supported by a regional manager. The quality and risk management programme include 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 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. There is an internal audit programme that is followed and reported on. An education and training programme have 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 report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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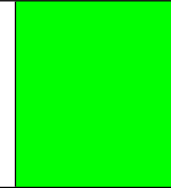
The registered nurse is responsible for each stage of provision of care. Initial assessments are completed by a registered nurse. Care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans and worklogs (developed on the electronic resident system) are 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. 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 medication guidelines. Medication charts are reviewed three-monthly.

Meals and baking are prepared and cooked off-site by a contracted service and delivered to St Helena's. Kitchenhands manage the facility kitchen and serving of meals. 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.

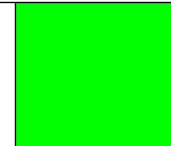


Standards applicable to this service fully attained.

The building has a current building warrant of fitness.

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.

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 was one resident with restraint and no residents using enablers. Staff receive regular education and training on restraint minimisation and challenging behaviours.

Infection prevention and control

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

Standards applicable to this service fully attained.

Standardised definitions are used for the identification and classification of infection events. The infection control coordinator (facility manager/clinical manager) is responsible for the collation, analysis and trending of data. 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)
Standards	0	17	0	0	0	0	0
Criteria	0	43	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: 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. Compliments, suggestions or complaints forms are available within the facility. There has been one verbal complaint since the last audit. The complaint register includes relevant information regarding the complaint. The complaint reviewed included acknowledgement, resolution and information provided regarding access to advocacy. The required timeframes for complaint management as determined by the Health and Disability Commissioner, had been met.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Residents (four rest home) and family members (two hospital and one rest home) interviewed stated they were welcomed on entry and were given time and explanation about services and procedures. They also stated they are informed of changes in the health status of residents and 11 incidents/accidents reviewed, confirmed this. Resident/relative meetings are held three-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).</p>

conducive to effective communication.		
<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>	FA	<p>Radius St Helena's is part of the Radius Residential Care group. The service currently provides rest home and hospital level care for up to 53 residents. On the day of the audit there were 51 residents (18 hospital residents and 33 rest home level residents). There were three rest home residents and two hospital residents under the long-term chronic health condition contract. All other residents were under the ARCC.</p> <p>There is site-specific business plan 1 April 2018 to 31 March 2019 that has been reviewed and links to the Radius 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 by the quality meeting to report on achievements towards meeting business goals including meeting the organisation key performance indicators for quality data.</p> <p>The facility manager has been in the role for six months and was previously the clinical nurse manager for two and a half years. She is supported by a clinical nurse manager, who has been in the role since August 2018 and was on leave during the audit. The regional manager and the management team was present during the days of the audit. The facility manager provides weekly reports to the regional manager who visits the facility fortnightly. She is available at any other time to the facility manager. The facility manager has maintained more than eight hours of professional development activities related to managing an aged care facility including induction for eight weeks and attendance at the annual Radius two-day conference. She is currently completing a diploma in leadership and management.</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 St Helena's. Quality and risk performance are 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 quality/health and safety and infection control meetings where all quality data and indicators are discussed. There are registered nurse (RN) meetings and general staff meetings. Minutes of these meetings are made available to all staff. Required actions and resolutions from facility meetings are documented. Resident/relative meetings are held monthly and concerns raised had been addressed and feedback at the meeting.</p> <p>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 October 2018 was predominantly 'quite satisfied to very satisfied'.</p> <p>The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at national level</p>

		<p>every two years. Clinical guidelines are in place to assist care staff.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Corrective action reports are required for any results less than 95%. Corrective actions are evaluated and signed off when completed. Outcomes of internal audits are discussed at facility meetings.</p> <p>Risk management, hazard control and emergency policies and procedures are in place. The Health and Safety (H&S) Committee comprise of the health and safety officer and representatives from each area. H&S officer has completed H&S training August 2016 and fire and emergency warden training August 2017. The meeting agenda includes a review of incidents/accidents and hazard management. Hazard report forms are reviewed by the committee and updated on the hazard register. There is a current hazard register. Contractors receive an induction.</p> <p>Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions. The service has a corrective action plan around reducing the number of falls below the organisational benchmark level, including analysis of time and location of falls. A RN is the falls champion and involved in reviewing falls and completing individual falls screening for any resident with over two falls in a month. Families are involved in falls prevention strategies including the purchase of hip protectors for their relative.</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>	<p>FA</p>	<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 quality/health and safety meetings including actions to minimise recurrence. A review of 13 incident/accident forms from December 2018 (skin tears, falls, bruises and one absconding) identified that forms are fully completed and include follow up by a RN. Corrective action plans had been completed and signed off. Care plans had been updated to include new interventions. Neurological observations were completed for three 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 have been four section 31 notifications made since the last audit, for two stage III pressure injuries, one resident to resident assault and the change in facility manager.</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>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one clinical nurse manager, one RN, two HCAs, one activities coordinator and one kitchenhand) 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.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. Staff are required to complete written core competencies during their induction which are repeated annually. 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. Skin, wound care and pressure injury prevention education was provided in August 2018 with over 50% attendance. For all staff who do not attend education, they are required to read the training content and sign the reading form. Staff receive reminders of upcoming education through the time target system, at handovers and text messaging. Repeat sessions are also provided and questionnaires/competencies followed up. The previous finding around skin care education and low staff attendance has been addressed.</p> <p>Three of five RNs have completed their interRAI training with another three registered to attend. Registered nurses are supported to maintain their professional competency.</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>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Residents and family members interviewed report there are sufficient staff numbers. There is a full-time facility manager and clinical nurse manager who work from Monday to Friday and provide on-call. The hospital/rest home beds are divided into five wings: Moorhouse (fifteen beds) has eight rest home and six hospital level residents; Bealey (seventeen beds) has eleven rest home and six hospital residents; Fitzgerald (nine beds including the assessed double room) has six rest home and three hospital residents; Deans (six beds) has five rest home and one hospital residents; and the Avenue (six beds) four rest home and two hospital level residents.</p> <p>There is a RN on duty 24 hours. On the morning duty there are six HCAs (three full shifts and three finishing at 1.30 pm). There are five HCAs on the afternoon shift (2 full shifts and 3 short shifts- one finishing at 2130 and the 2 others at 2200hrs). On night shift there are two HCAs and one RN.</p> <p>The activities coordinator works from 9 am to 4 pm Monday to Friday. There is a full-time administrator and a maintenance person. There are two cleaners on Monday to Friday and one at the weekends. There is a morning and afternoon kitchenhand daily.</p> <p>Staff interviewed state they are well supported by the management team.</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>	<p>FA</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. Registers nurses and senior HCAs administer medications and have completed medication competencies and medication education. All medications are stored safely in the one medication room. Medication administration was observed to be compliant with the administration policy. Medications are delivered in blister packs and these are checked by the RN against the handwritten GP medication chart. There were two rest home residents self-medicating who have a self-medication competency. There are daily checks carried out for residents self-medicating. Locked drawers were sighted. The medication fridge is monitored daily. The eye drops and creams/ointments have been dated on opening.</p> <p>Ten medication charts (paper-based) were reviewed and met prescribing requirements. The GP has reviewed the medications at least three-monthly. All medication charts had photo identification and allergy status noted. As required medications had indication for use.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is contracted and all meals are prepared and cooked at another Radius facility located nearby. Food is transported in cold and hot boxes to the facility in a specialised van into the kitchen at St Helena's. Hot meals are then served from a bain marie in the kitchen which is adjacent to the dining room. Plates are warmed prior to the meals being served and serving temperatures are taken and recorded. St Helena's employ morning and afternoon kitchenhands for the serving of meals including morning and afternoon teas. Breakfasts are prepared in the facility kitchen. The kitchenhand (interviewed) receives information on residents' dietary requirements, likes and dislikes. The chef manager at the main site is kept informed of any dietary changes and meets with the kitchenhand and management weekly and receives feedback from the resident meetings. There are additional snacks and foods available in the kitchen for resident's afterhours as required. Special dietary requirements are accommodated including pureed meals. There is special equipment available for residents if required.</p> <p>The food control plan for the contracted company been verified and expires 14 November 2019. The temperatures of fridges, freezers and chiller in the facility kitchen are monitored and recorded. The chemical provider checks and monitors the performance of the dishwasher. All food is stored appropriately and dated. A cleaning schedule is maintained. The thermometer is calibrated monthly.</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>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are</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. A care summary was available to care staff on e-Case outlining cares and individual needs. Allied health involvement was linked to the long-term care plans. Residents and their family/whānau confirm they are involved in the care</p>

<p>consumer focused, integrated, and promote continuity of service delivery.</p>		<p>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. The previous finding around documented interventions in the care plans have been addressed.</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 state they are contacted for any changes in the resident's health. Conversations with relatives are 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. Short-term care plans were in place for wounds. On the day of audit there were fourteen residents with wounds (skin tears, abrasions, laceration) including one resident with a stage II facility acquired pressure injury of the buttock. The pressure injury care plan included appropriate interventions. There were adequate pressure injury resources available. The RN (interviewed) have access to specialist nursing wound care management advice through Nurse Maude who have been involved in non-healing wounds.</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. These include: turning charts; food and fluid charts; fluid output charts; blood pressure; weight charts; weekly weights; behaviour charts; blood sugar levels; pain monitoring charts; and neurological observations.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the</p>	<p>FA</p>	<p>The activity coordinator has been in the role 14 years and works Monday to Friday from 9 am to 4 pm. The rest home/hospital programme is integrated and reflects the resident's interests and preferences. The activity calendar is displayed throughout the facility. Residents interviewed know of the activities happening and are reminded of events such as entertainers and outings. Activities occur in the open plan dining/lounge area and there is a smaller lounge for quieter activities or visitors. The programme includes but not limited to: daily exercises to the Arthritis foundation DVD; garden walks and gardening; quizzes; word games; in-house movies; arts and crafts; and baking. One-on-one time is spent with residents who choose not or unable to participate in group activities such as reminiscing and pampering sessions (hand massage/manicures).</p> <p>Festive occasions and events are celebrated. There are inter-home activities with a local Radius facility, including bowls.</p>

<p>service.</p>		<p>Community visitors includes church services, monthly communion, entertainers, monthly pre-schoolers and primary school children. There are twice-weekly van outings. There is a shopping trip and the other outing is a scenic drive or visit into the community such as to the library, cafes, movies or other events. The van has wheelchair access. The activity coordinator has a current first aid certificate. Residents are encouraged to retain their community links and supported to attend these.</p> <p>The service has five residents under the age of 65 years with long-term chronic health conditions. The activity coordinator meets with them individually to plan and coordinate their activities/outings. The residents choose the group activities they would like to join and are supported to maintain their own interests including community involvement such as attending the Salvation Army group, community outings and movies. They have computers, access to internet and mobile phones to maintain contact with family and friends.</p> <p>All resident files reviewed have an individual recreational assessment (About me) and leisure plan on electronic system. The leisure plan 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 resident meetings and surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial 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. All care plans reviewed had been updated to reflect the resident's current supports/interventions to meet their goals. There were case conference multidisciplinary notes on the electronic e-Case system that evidenced relative/resident (as appropriate) involvement in care plan evaluations. Short-term care plans sighted had been reviewed regularly and either resolved or if ongoing updated on the relevant care plan. The previous finding around evaluation of long-term and short-term care plans has been addressed.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building warrant of fitness expires 1 July 2019. There is a maintenance requests log maintained and a planned maintenance schedule. There is an ongoing plan for resident room refurbishments. The vinyl flooring in the kitchen is currently being replaced.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme. The facility manager is mentoring a RN into the role of infection control coordinator. Currently the facility manager and clinical manager are collating infections by type and providing a monthly report including trends and analysis to the quality/health and safety/infection control committee. Meeting minutes 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 have been no outbreaks.</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 was one resident using a restraint (bed rails) and no residents with enablers. All necessary documentation is available in relation to the restraint. Staff training has been provided around restraint minimisation and challenging behaviours. Staff complete restraint minimisation competencies. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.</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.

No data to display

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

No data to display

End of the report.