

Radius Residential Care Limited - Radius St Joans 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 Joans Care Centre
Services audited:	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 29 May 2019 End date: 30 May 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	64



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 Joan's is owned and operated by Radius Residential Care Limited. The service is certified to provide rest home, hospital, (geriatric and medical), and intellectual and physical residential disability services for up to 98 residents. On the day of audit there were 64 residents.

The service is managed by a facility manager/registered nurse who has been in the role 10 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 Joan'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 general practitioners.

The one previous audit finding around maintenance has been addressed. A further shortfall around medication charts has been identified at this audit.

The service has maintained a continuous improvement rating around meal services.

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.
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There is open communication with residents and relatives, which also includes open discussion around incidents. There are two monthly resident/relative meetings which provide an opportunity for suggestions and feedback on the services provided at St Joan'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.
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The 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 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 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 with any quality improvements identified and implemented. 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

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

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 holds a current warrant of fitness. The facility is currently being refurbished.

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 no residents with restraint and two residents voluntarily 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 (enrolled nurse) 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	1	14	0	1	0	0	0
Criteria	1	39	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: 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 have been eight complaints in 2018 and two in 2019 to date. The complaint register (paper-based and electronic) includes relevant information regarding the complaint. The complaints reviewed included acknowledgement, investigation, 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 (three rest home and three hospital) and one family member of a hospital level resident interviewed, stated they were welcomed on entry and were given time and explanation about services and procedures. The relative confirmed they are notified promptly of any changes in their relative's health status or incidents/accidents. Seventeen incident/accidents for the month of April 2019 were reviewed and evidenced the next of kin had been notified within a timely manner. Resident and relative meetings are held two monthly. Quarterly newsletters keep residents and families updated on facility matters, services and feedback on survey results.</p> <p>The facility manager and clinical nurse manager have an open-door policy. The service has policies and</p>

conducive to effective communication.		procedures available for access to interpreter services for residents (and their family/whānau).
<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 Joan's is part of the Radius Residential Care group. The service currently provides rest home, hospital (geriatric and medical) and residential disability (physical and intellectual) levels of care. On the day of the audit there were 64 residents including 32 rest home level residents (including one resident under PAC funding and three residents under the Rest and Recuperation short-term contract) and 32 hospital level of care residents (including one resident under long-term chronic health condition contract and one younger person with a physical disability).</p> <p>There is an overarching Radius business plan 2017 – 2020. Radius St Joan's has a site-specific business plan 2018 – 2019 that includes the mission statement. Objectives are reviewed regularly and include achieving all internal audits above 95%, reducing falls below 25 per month, maintaining a restraint free environment and continuing with refurbishment and landscaping.</p> <p>The facility manager (registered nurse) has been in the role since July 2018 and previously as the clinical nurse manager since 2017. She is supported by a clinical nurse manager, who has been in the role since August 2018 and previously as a registered nurse at the facility for two years. The clinical nurse manager was on leave during the audit, however, was present for an interview. The regional manager (also a registered nurse) was present during the days of the audit and oversees the operations of four Hamilton Radius facilities. The facility manager provides weekly business management reports to the regional manager who visits the facility regularly. She is available at any other time to the facility manager.</p> <p>The facility manager is a registered nurse with a current practicing certificate and has completed orientation to the role including marketing, funding and ARC contracts. She has maintained at least eight hours of professional development activities and attends the DHB cluster meetings. The clinical nurse manager completed orientation to the role and has maintained eight hours of professional development.</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</p>	FA	<p>There is an organisational quality and risk management plan in place. 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 daily triangle of support meetings (facility manager, clinical nurse manager and administrator) and weekly head of department meetings. There are monthly staff/quality/health and safety and infection control meetings where all quality data and indicators are discussed. There are registered nurse (RN)/enrolled nurse (EN) meetings. Minutes of meetings are made available to all staff. Required actions and resolutions from facility meetings are documented.</p> <p>Annual resident/relative satisfaction surveys are completed with results communicated to residents, relatives and staff. The overall service result for the resident satisfaction survey completed in September 2018 was 90% very satisfied. A food satisfaction survey in April 2018 was 90% satisfaction with meals.</p>

<p>continuous quality improvement principles.</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 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 (accidents/incidents, staff incidents, infection control, hazards, compliments/complaints and internal audit outcomes. An internal audit schedule has been completed. Corrective action reports and re-audits are required for any audit 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. Health and safety goals are included in the site-specific quality plan. Health and safety is an agenda topic at the staff/quality meetings and staff have the opportunity to raise any health and safety concerns/issues. The facility manager oversees health and safety. The staff/quality meeting agenda includes a review of incidents/accidents and hazard management. There is a current hazard register reviewed May 2018.</p> <p>Falls prevention strategies are in place including regular resident checks, use of bell mats, GP reviews to exclude medical causes and physiotherapy assessment. The "strong and stable" group has been formed and linked to the DHB with physiotherapy services to reduce falls. The service has reduced falls down to nine in the month of March.</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 and corrective action to minimise incidents/accidents. Incidents are included in the Radius key performance indicators (KPI). There is a discussion of incidents/accidents at the monthly staff/quality and clinical meetings including trends, analysis and actions to minimise recurrence. A review of 17 incident/accidents from April 2019 (skin tears, falls, bruises and one absconding and two pressure injuries) identified that electronic 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 two unwitnessed falls. 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 no incidents or outbreaks to report.</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. Five staff files reviewed (one clinical nurse manager, one RN, one enrolled nurse, one HCA and one activity coordinator) included a recruitment process which included reference checking, signed employment contracts, job descriptions, 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 covers mandatory requirements and exceeds eight hours annually. The education coordinator (enrolled nurse) maintains a record of individual staff attendance. The service combines up to three mandatory education topics within one session every three months, which has improved staff attendance for mandatory education. Other education is provided by external speakers such as dementia care specialist and hospice nurses. 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. Staff complete competencies relevant to their roles including medication, syringe driver, food safety, restraint, and fire safety.</p> <p>There is eLearning available for Careerforce level two and three with an in-house leadership programme for level four. Radius have two Careerforce assessors.</p> <p>Five of eleven RNs have completed their interRAI training. 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 the family member interviewed reported there are sufficient staff on duty. There is a full-time facility manager and clinical nurse manager who work from Monday to Friday and provide on-call.</p> <p>On the day of audit there were 32 rest home residents and 32 hospital level of care residents.</p> <p>The rest home wing (29 beds – includes one double room) had 23 rest home residents on the day of audit. There is an RN on duty in the rest home on Wednesdays and available 24 hours from the hospital wing. There are two HCAs on morning shift (one full shift and one until 2.30 pm), two HCAs on afternoon shift (one full shift and one until 8 pm) and one HCA on night shift.</p> <p>The hospital wings are: Charlotte – four beds with one hospital resident; Laura – 15 beds (including seven double rooms) with six hospital residents; Norman – 15 beds (including seven double rooms) with three hospital and one rest home resident; Doris – 20 beds with 13 hospital and three rest home residents and Jebson - 15 beds with five rest home residents and nine hospital residents.</p> <p>On morning shift in the hospital there is an RN and EN seven days a week. There are six HCAs on the full shift and</p>

		<p>two HCAs until 2.30 pm. On afternoon shift there are two RNs (or one RN and one EN), four HCAs on full shift and four HCAs until 8 pm. There is one RN and three HCAs on night shift.</p> <p>Three activity staff cover five days a week with one on Mondays and Fridays, two on Wednesdays and three on Tuesdays and Thursdays.</p> <p>There is a full-time administrator, full-time maintenance person and part-time gardener. There are designated cleaning and laundry staff seven days a week.</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>	PA Low	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were two residents self-administering on the day of audit. All policies and procedures had been adhered to. There were no standing orders. There were no vaccines stored on site.</p> <p>The facility uses a paper-based and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs, ENs and senior medication competent HCAs administer medications. All staff have up-to-date medication competencies and there has been annual medication education. Five RNs have syringe driver training completed by the hospice. The medication fridge temperature is checked daily. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on medication sheets. Twelve medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed. Not all medication charts met prescribing requirements.</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>	CI	<p>The service has a head cook who works Saturday to Thursday 6.45 am – 2.45 pm. There are two other cooks, one who works on a Friday 6.45 am – 2.45 pm and another who is a back-up cook and also works 4.30 pm – 8.30 pm. There are three kitchenhands on a roster who work 6.30 am – 2.00 pm and 11.30 am – 6.00 pm. All kitchen staff have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served in the rest home dining room from a bain marie. Meals are transported to the hospital dining rooms in hot boxes. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the first day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. A breakfast club is held monthly, which has increased in numbers attending.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is</p>

		<p>reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a whiteboard. The four-weekly menu cycle is approved by a dietitian. The food control plan has been verified and is not now due until 31 March 2020.</p> <p>Residents and the one family member interviewed were satisfied with the meals.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and the one family member interviewed confirmed this. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. Care staff interviewed, stated that they found the care plans very useful and a guide for care needed.</p> <p>Resident falls are reported electronically and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their head. Family are notified.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>There are currently two pressure injuries, one stage one and one stage two. One is non-facility acquired. Pressure injury prevention equipment is available and is being used. HCAs document changes of position electronically.</p> <p>Wound assessment, wound management and evaluation forms are documented electronically, and wound monitoring occurs as planned. There are currently fourteen wounds being treated (including the two pressure injuries). All other current wounds are non-complex.</p> <p>Electronic monitoring forms are in use as applicable such as weight, vital signs, wounds and behaviour.</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>	FA	<p>There is an activities coordinator who works Monday to Wednesday six and a half hours daily and there are two activities coordinators; one works Tuesday to Thursday six and a half hours daily and one works Thursday and Friday six and a half hours daily. They will also come in at weekends to set up for special activities if required. The activities coordinator holds a first aid certificate. On the days of audit, residents were observed listening to a newspaper reading, doing exercises, playing bowls, watching a movie, and playing Uno.</p> <p>There is a weekly programme in large print on noticeboards and residents also have a copy in their rooms. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. The activities team always notify the residents of any major sporting event. The rest home and hospital combine for some activities.</p>

<p>service.</p>		<p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There is a pastor who works 9.00 am – 4.00 pm on a Monday and 9.00 am – 12 noon on a Thursday. The pastor is also on call if required. There is an interdenominational church service every Monday and communion is held monthly. A Catholic Sister comes in every Wednesday for Catholic communion.</p> <p>There are van outings twice monthly in the rest home and hospital. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mother’s Day, Anzac Day and the Melbourne Cup are celebrated. There is a mid-winter Christmas lunch coming up. Breakfast club is held monthly.</p> <p>The facility has three cats and one resident has a budgie. There is also canine therapy every Monday and Saturday. The gardener has a dog which comes to work, and the residents just love it. One resident, who can become agitated, always calms down if the dog is brought into the room.</p> <p>The facility is currently building a sensory garden. This will have built-up garden beds, so residents will have easy access for gardening activities.</p> <p>There is community input from pre-schools and schools, choirs and Kapa Haka groups. Residents go out to the RSA, stroke club and the working men’s club.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the resident’s past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held two monthly. Residents interviewed expressed satisfaction with the activities.</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>Four care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. The other two care plans were for residents who were on a rest and recuperation and post-acute care contract. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, activities coordinator and resident/family if they wish to attend. There are three-monthly reviews by the GP for all residents. The family member interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 1 December 2019. There is a preventative and reactive maintenance programme in place. Currently the facility is refurbishing the whole building wing by wing.</p>

<p>provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>There is a new sensory garden area being established. Access to this area is blocked for safety reasons.</p> <p>Healthcare assistants interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents.</p> <p>The vinyl flooring in the Norman and Laura wings have been replaced. The previous finding has been addressed</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 infection control coordinator is an enrolled nurse who has completed external infection control education. All infections are reported in the eCase system and a monthly report including end of month trends and analysis is generated. Data including corrective actions is discussed at the management and facility meetings. Corrective actions are implemented where upward trends are identified for infections. 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>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The service has documented systems in place to ensure the facility remains restraint free. On the day of audit there were no residents with restraint and two hospital residents voluntarily using bedrails as enablers. The enabler use is reviewed three monthly and there is two hourly monitoring when in use. Staff training has been provided around restraint minimisation and challenging behaviours. Staff complete restraint minimisation competencies.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	The facility uses a paper-based system and GPs prescribe and sign for medications on medication charts. The GPs writing is legible. They review medication charts three monthly, allergy status is recorded, and ‘as required’ medications had indications for use prescribed. Each medication had not been dated individually.	Three out of six hospital medication charts and three out of six rest home medication charts evidenced the use of brackets to date medications.	<p>Ensure each medication prescribed is dated individually.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	<p>The service has continued with the breakfast club, which now has a membership of up to 32 residents who regularly attend each month. The service has maintained a continuous improvement rating around meal services.</p>	<p>The breakfast club started in 2016 and was discussed at a residents’ meeting in February 2017 and residents elected to have this every third Tuesday of the month. The number of residents attending increased from the initial ten rest home and three hospital residents to 27 residents regularly attending throughout 2017. These numbers have been consistent throughout 2018 and 2019 to date, with 27-32 residents attending regularly. At a recent resident meeting there were requests for spaghetti and baked beans be added to the breakfast club menu and this has been initiated with great success. Some residents, who want to participate but are unable to get to the dining room at 8.30 am, now have a cooked breakfast delivered to their room on breakfast club mornings. Residents interviewed were very satisfied with the breakfast club menu and looked forward to breakfast club days including the socialisation. The food survey for 2019 was 90% meal satisfaction.</p>

End of the report.