

Radius Residential Care Limited - Radius Potter Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Radius Residential Care Limited
Premises audited:	Radius Potter Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 18 February 2020 End date: 19 February 2020
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:	53

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 Potter Home is owned and operated by Radius Residential Care Limited. The service provides care for up to 57 residents requiring rest home, hospital and residential physical disability level of care. On the day of the audit there were 53 residents. 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, and relatives interviewed spoke positively about the service provided at Potter.

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 and general practitioner.

The service has been awarded continuous improvements around meeting the recreational preferences for the younger persons who reside at the facility, good practice, falls reduction and reduction in infection rates.

Consumer rights

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

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

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.

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 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.
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There is an admission package available prior to or on entry to the service. 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 medication competent healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The diversional therapist 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.

Residents commented positively on the meals.

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.

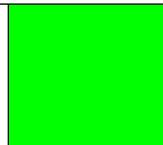


Standards applicable to this service fully attained.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are two shared rooms, but the rest of the rooms are single. All rooms have hand-basins but share communal toilets and showers. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

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 were five residents using restraints and two 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.

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

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)
Standards	3	47	0	0	0	0	0
Criteria	4	97	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with nine care staff, including six healthcare assistants (HCA), two registered nurses (RN) and one diversional therapist confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Five residents (two rest home and three hospital including two younger persons with a disability (YPD) and one on respite ACC contract) and nine relatives (four rest home and five hospital including family of a YPD and respite resident) 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 July 2019.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (two rest home and six hospital including one young person with a disability [YPD], one respite ACC and one long term chronic health care [LTS-CHC]). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care and residents and families interviewed agreed. Enduring power of attorney (EPOA) evidence is filed in the residents' charts.</p>

informed consent.		
<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	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 included information on residents' family/whānau and chosen social networks.
<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	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, (eg, café connection groups, local rest home meetings, attending cafes, and restaurants). Interviews with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Radius Potter has eight residents on YPD contracts (seven hospital and one rest home). These residents are engaged in a range of diverse activities including (but not limited to) social groups, local gym, swimming programmes, community outings and sports events. Relatives and friends are encouraged to be involved with the service and care.
<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	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 the foyer. 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 12 complaints made in 2018 and 14 received in 2019. There have been two complaints for 2020 year to date. Documentation reviewed identified the service is proactive in addressing complaints. 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>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 include 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. 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	<p>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. The 2019 satisfaction survey identified 100% of residents were happy with privacy. Church services are held, and contact details of spiritual/religious advisors are available to staff. Staff education and training on abuse and neglect has been provided, last occurring in May 2019. Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity.</p>
<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	<p>Radius Potter Home 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 two residents who identified as Māori. One Māori resident file was reviewed and included a Māori health plan. Links are established with local Māori primary health Mahitahi Hauora and other community groups as requested by the resident/family. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Interviews with staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Cultural safety training was last provided in March 2019.</p>
<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	<p>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 involvement is encouraged (eg, invitations to multidisciplinary and resident meetings and facility functions). Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<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 provide 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>CI</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. The resident satisfaction survey reflects high levels of satisfaction with the services received. 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. There are implemented competencies for healthcare assistants and registered nurses.</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 fourteen incidents/accidents sampled confirmed this. Resident/relative meetings are held 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, interpreter services are made available. Communication needs and use of alternative information and communication methods are available and used where applicable.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Radius Potter Home is part of the Radius Residential Care group. The service currently provides rest home, hospital and residential disability (physical) for up to 57 residents. On the day of the audit there were 53 residents, 18 rest home and 35 hospital level residents. This includes one rest home and seven hospital residents on younger persons with disabilities (YPD) contracts, one hospital resident on a long-term support chronic health condition (LTS-CHC) contract and two hospital residents funded by the ACC on respite contracts. Six beds in the rest home wing are dual purpose. All other residents were under the age-related residential care (ARRC) contract.</p> <p>The Radius Potter business plan 1 April 2019 to 31 March 2020 is linked 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 to report on achievements towards meeting business goals.</p> <p>The facility manager has been in the role for seven years. She is supported by a clinical nurse manager, who has been in the role since 2013 and an administrator who has been in the role for one year. The regional manager also supports the facility manager in the management role and was present during the</p>

		<p>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 Radius Potter. 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 with input from the clinical nurse manager. 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. All residents including those on YPD contracts are encouraged to make suggestions and have input into services. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. Surveys include young people with disabilities around issues relevant to this group. The overall service result for the resident/relative satisfaction survey completed in August 2019 showed increased satisfaction on previous years. No trends or corrective actions were identified.</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 service's policies at national level every two years. Clinical guidelines are in place to assist care staff. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. Data is collected in relation to a variety of quality activities and an internal audit schedule is being completed. Areas of non-compliance identified through quality activities are actioned</p>

		<p>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 (maintenance staff) interviewed confirmed their understanding of health and safety processes. The H&S rep has completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. Hazards are lodged electronically and on hazard identification forms and an up-to date hazard register (last reviewed in January 2019) is in place. 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 fourteen electronic incident/accident forms from January and February 2020 identified that forms were fully completed and include follow-up by a RN. Neurological observations were completed for 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 facility acquired pressure injuries (one unstageable and one stage three) and one community acquired stage four pressure injury. A resident fracture following a fall was also notified.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (one clinical nurse manager, two RNs, three HCAs, one activities coordinator and one chef) included a recruitment process which included reference checking, signed employment contracts and job descriptions, code of conduct and non-disclosure agreements, 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.</p> <p>Staff are required to complete written core competencies during their induction. These competencies are repeated annually. There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Two of eight RNs and the clinical nurse manager have completed their interRAI training.</p>

		Registered nurses are supported to maintain their professional competency. Healthcare assistants are encouraged and supported to achieve NZQA standards. Staff training has included sessions on communication and sexuality and intimacy to ensure the needs of younger residents are met.
<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 (RN) and clinical nurse manager who work from Monday to Friday. A staff educator (enrolled nurse) works four days a week.</p> <p>There is a registered nurse (RN) on duty each shift, plus an additional RN 10 am to 7 pm Friday, Saturday, Sunday and Monday. The RNs are supported by adequate numbers of HCAs.</p> <p>The staff are rostered as one group and allocated groups of residents each shift. There are eight healthcare assistants on morning shift (four long, three six hour and one four-hour shift), seven healthcare assistants on afternoon shift (four long, two six hour and one four-hour shift). There are three healthcare assistants on night shift.</p> <p>Staff working on the days of the audit, were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff stated that overall, the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files 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. All resident files are stored electronically and protected from unauthorised access by password protection.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.</p>

services has been identified.		
<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>Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the 'yellow envelope' transfer system. Communication with family is made.</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>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were two rest home residents self-administering on the day of audit. Consent forms had been signed and the residents deemed competent to self-administer. Medications were in a locked drawer. There were no YPD residents capable of self-administering. There are no standing orders. There are 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 and senior medication competent HCAs administer all medications. Staff attend annual education and have an annual medication competency completed. All RNs are syringe driver trained by the hospice. The medication fridge and medication room temperatures are checked daily. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the paper administration sheet. Sixteen medication charts were reviewed (twelve hospital and four rest home). Medications are reviewed at least three monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service has two cooks who cover Monday to Sunday and kitchen assistants who cover morning and afternoon shifts Monday to Sunday. All cooks 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 each area from hot boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well-presented and residents in the rest home dining room said the meal was very nice.</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</p>

		<p>likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The four weekly menu cycle is approved by the Radius dietitian. All resident/families interviewed were satisfied with the meals. The head cook said residents were vocal if they did not like anything. The cook communicates with the residents regularly.</p> <p>The food control plan was certified on 12 October 2018.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</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 to the potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall the goals were identified through the assessment process and linked to care plan interventions. Other electronic assessment tools in use included (but not limited to) nutrition, continence and pain.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions documented support needs and provide detail to guide care. All YPD residents have input into their care and there are clear guidelines in their care plans around specific cares such as positioning and speech. Electronic care plans are updated when changes in health status occur. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, wound care nurse and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow and that they have adapted to the use of electronic care plans.</p>
<p>Standard 1.3.6: Service</p>	FA	<p>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed.</p> <p>Resident falls are reported on the electronic accident register and written in the progress notes. Neurological observations are taken when there is a head 'knock' or for an unwitnessed fall. 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>Wound assessment, wound management and wound evaluation forms are on the electronic wound register. Wound monitoring occurs as planned. There are currently fourteen wounds being treated. There are currently two facility acquired pressure injuries. One is a stage two and one is a stage four. The stage four pressure injury was originally an unstageable. This was debrided at NDHB. The district nurse has visited since return from hospital, and there are photos of the pressure injury's progress.</p> <p>Electronic monitoring forms are in use as applicable such as weight, turning charts, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging 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 service.</p>	<p>CI</p>	<p>There is one diversional therapist who works 35 hours a week Monday to Friday. If there is a special event on at the weekend the DT will come in. On the day of audit residents were observed playing bingo, going out for walks, going out to swimming, doing arts and crafts and the ladies had a van outing.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Every Monday each resident is given a copy of the weekly programme to keep in their room. 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.</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 weekly interdenominational church service and weekly Catholic communion.</p> <p>There is a men's van outing every Monday afternoon and a ladies' van outing every Wednesday afternoon. Special events like birthdays, Easter, Mothers' Day, Matariki, Anzac Day and the Melbourne Cup are celebrated. There is weekly entertainment.</p> <p>The facility has three cats and staff bring in their pets to visit.</p> <p>There is community input from the local preschools and schools as well as the library. Residents go out to 'Mix and Jingles' – local rest homes meet, have afternoon tea and there is entertainment or a talk. Residents also go out to 'Café Connection' – local church groups meet and greet, and morning tea is</p>

		<p>provided. Every second Friday there is an outing to a local restaurant.</p> <p>YPD residents are welcome to join in any activities. Two of them go to stroke club and one goes to the gym regularly. They also play croquet on the front lawn. In 2018, YPD residents plus some rest home residents suggested that they would like to go swimming. After discussion the Potter swim team was 'born' in February 2018. The aim was to build confidence, wellbeing and to have a fun exercise regime. This has been a great success and is still happening every Tuesday all year round.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual 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.</p> <p>Resident meetings are held monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All long-term care plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the dietitian, mental health services for older people and the district nurse. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff.</p>

<p>harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</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 holds a current warrant of fitness which expires 1 July 2020. There is a maintenance person who works full time five days a week. Contracted plumbers and electricians are available when required. There is also a contracted gardener.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges, hallways and bedrooms are carpeted. The corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. All YPD residents using wheelchairs have their own personal wheelchairs.</p> <p>HCA's interviewed stated they have adequate equipment to safely deliver care for the residents.</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>	<p>FA</p>	<p>All rooms have hand basins. All toilets and showers are communal. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are signs on all shower/toilet doors.</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>	<p>FA</p>	<p>There are two shared rooms. A married couple are happy to share one room and the other room is shared by residents who gave their consent. All other rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. The two shared rooms have privacy curtains. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</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 large and small lounges. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. The dining rooms are spacious. There is a hairdressing salon. All YPD residents reside in the same wing and have a dedicated and spacious lounge.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is done off site. All dirty laundry is bagged and placed on a covered deck ready for pick-up. Clean laundry when returned is placed on a clean trolley. Personal laundry is placed in individual net bags. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away. All chemicals on the cleaner's trolley were labelled. There is a sluice room for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room is kept closed when not in use.</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>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters including an evacuation covering the specific needs of younger people with disabilities. There is a minimum of one first aid trained staff member on every shift and during outings. The facility has an approved fire evacuation plan. Fire drills take place every six months. Smoke alarms, sprinkler system and exit signs are in place. Gas barbeques and torches are available in the event of a power failure. Emergency lighting is in place which is regularly tested. A civil defence kit is in place. Supplies of stored water and food are held on site and are adequate for three days. Electronic call bells are evident in resident's rooms, lounge areas and toilets/bathrooms.</p> <p>The facility is kept locked from dusk to dawn. The service utilises a security camera to promote resident safety.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. Heating is from water heated radiators which are in all areas. Staff and residents interviewed stated that this is effective. There are two outdoor areas where residents smoke. All other areas are smoke free.</p>

that is maintained at a safe and comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Radius Potter 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 staff educator (EN) is the designated infection control nurse with oversight from the clinical nurse manager. There is a job description that outlines the responsibility of the role and reporting requirements. The Radius infection control programme is 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 training at the Northland District Health Board in October 2019. She has access to ongoing education and resource persons including Bug control newsletters/training, DHB infection control nurse, the radius regional manager, 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 June 2019. 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>	<p>FA</p>	<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 toolbox talks are also provided.</p> <p>Resident education is expected to occur as part of providing daily cares.</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>CI</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. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. 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 have been no outbreaks since the previous audit.</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 five residents using restraints (three bed rails and two lap belts) and two residents using an enabler (both bed rails). All necessary documentation is available in relation to the restraints. Staff training has been provided around restraint minimisation in September 2019. Annual restraint competencies are completed by all staff. 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</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>

providers and others.		
<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>	FA	<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. Three 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</p> <p>Services use restraint safely</p>	FA	<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 an electronic restraint monitoring worklog and reflects the actual times monitoring occurred, evidenced in three resident files where restraint was being used.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). A review of three resident files identified that evaluations are up to date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint minimisation programme is discussed and reviewed at the monthly clinical and 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.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Radius Potter have collaborated with the Northland DHB practice development aged residential care nurse to reduce emergency number presentations by identifying and treating residents as soon as symptoms present.</p>	<p>In 2016 Radius Potter were aware that the rate of presentations to the emergency department from Radius Potter was significantly higher than other similar services. As a result of this an action plan was developed to ensure where possible early intervention prevented unnecessary visits. Care staff made use of a STOP and WATCH tool to quickly identify deteriorating residents and provide a communication pathway for escalation of a resident’s condition. By using this tool, RNs made prompt assessments with referrals to GPs made in a timely manner. GP referrals now use the SBAR format ensuring full and comprehensive information is provided pre visit. Registered staff have been encouraged to attend external and DHB training opportunities and are supported by the experienced CNM and FM. The CNM has attended critical assessment skill training improving her support for RNs. Advanced care directives are discussed with all residents and their family on admission and clear information of their preferences for medical intervention is well documented. The DHB provides education on the use of advanced care directives to all registered staff. As a result of the above initiatives medical presentations have reduced from 17 or 6.9% of aged care admissions in 2016 to 10 or 3.7% in 2019. In 2016 Radius Potter presentations were 6th highest of 24 similar contributing ARC facilities. This has reduced each year since to 14th in 2019. Radius Potter has been successful in preventing unnecessary presentations to the DHB</p>

			emergency department.
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Radius Potter staff recognise that falls can cause harm in the elderly and can bring about a reduction in their quality of life. This has an effect on the person's physical deterioration and also has an effect on the resident psychologically, with them developing anxiety and fear of falling again. With this in mind, Radius staff had implemented various strategies to reduce hospital resident falls rates. In March and June following an unexpected increase in falls, strategies were re-evaluated.</p>	<p>Potter Home's fall rate median in the last 4 years has been 11.3. In June 2019, the service introduced a number of new initiatives. Improved strategies included: Monthly analysis of falls, together with falls mapping, to identify where the falls are happening and early recognition of trends so that corrective action plans can be implemented. Frequent fallers are identified, reviewed, and a care plan implemented with robust fall reduction measure is in place. Staff education has been provided both as part of the routine education planners, with additional manual handling and falls prevention training and toolbox talks around prompt answering of residents call bells, especially high falls risk residents and those with sensor mats. The purchase and use of sensor mats has been increased and intentional rounding for residents with high risk for falls. Residents are charted with Vitamin D to help with bone strength and minimising injury in case they fall. Residents at high risk of falls have been relocated closer to the nurse's station. All residents are assessed post falls to rule out delirium and prompt referral are made to GPs for review. The service has collaborated closely with Northland DHB to monitor emergency department visits providing further opportunities to improve service.</p> <p>As a result of the above initiatives, hospital falls in the last year have trended down and falls with harm have also trended down. The median for Radius Potter Home falls rate per 1000 bed days for hospital residents has decreased from 11.3 to 6.3 since July 2019. All results since July 2019 have been consistently well below the radius medium.</p>
<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>Every Tuesday a group of YPD and rest home residents participate in a swimming programme in the local hydrotherapy pool. They are accompanied by the DT who gets in the pool with them and an enrolled nurse who assists with getting in and out and with drying and dressing. The</p>	<p>Following on from resident requests in February 2018, a swim team was commenced with a positive impact on YPD residents as follows:</p> <p>Resident one was very nervous when first going to the pool and would not let go of the bars around the sides. After a few sessions, confidence and trust grew and the resident now walks from one end of the pool to the other. The resident tells everyone 'I'm off to the pools' and really looks forward to Tuesday mornings.</p> <p>Resident two has an exercise regime which is not enjoyed, and staff find it difficult to get the resident to do it. However, on pool therapy days races to get into the van and then into the water seeing the pool as fun and providing an excellent exercise programme.</p> <p>Resident three has back, and shoulder pain and exercising can be painful. The pool makes the resident weightless, so exercise is more enjoyable. The pool facility has a</p>

		<p>aim is to build confidence, wellbeing and to have a fun exercise regime. The pool is heated and has equipment to facilitate access for the disabled. Residents interviewed stated that this is a highlight of their week.</p>	<p>water wheelchair, so this makes access to the water a simple process.</p> <p>Resident four stated that the water really helps with balance and strengthening leg muscles. The resident also attends the gym and has an exercycle but stated that going to the pool gives a sense of freedom not obtained with any of the other exercises.</p> <p>Resident five has always loved swimming and finds that being in the water helps strengthen both knees and the social interaction is enjoyable as well.</p> <p>Resident six was very active prior to a stroke. The resident walks every morning but will not join in the exercise class or any other activities. The DT gently persuaded that the pool would be a good way to exercise and now happily exercises and interacts with the other swimmers.</p> <p>The above are examples of the benefits of the Potter swimming group. Seeing the vast improvement with confidence and strength along with the social aspect the facility will continue to encourage more people to join the group. Feedback from residents is that swimming has helped them feel better, feel stronger and have increased enjoyment of life.</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>The surveillance monitoring system includes analysis of trends for all types of infections. The infection control coordinator, alongside the registered nurses are continually reviewing any trends identified in surveillance analysis and when trends are identified plans are developed to address these. As a result of initiatives introduced over the last three years, Radius Potter has consistently reduced overall infection rates.</p>	<p>Potter Home staff have been working to lower infection rates where possible through the use of ongoing re-enforcement of good hand hygiene practices and education opportunities for residents, staff and visitors. Throughout the year the service utilises a black light in education sessions to highlight hand areas that are missed and ensuring a good understanding of hand hygiene and prevention of cross infection. Residents are educated around hand hygiene particularly at mealtimes and after toileting. HCAs are educated to alert the RNs of any skin tears immediately which assists in timely dressings, therefore limiting the chance of infection and ensuring faster healing times. Staff have been educated around fungal infections and the need for careful drying of skin, especially in humid weather. A particular emphasis on ensuring adequate hydration has been assisted by the introduction of ice blocks on a regular basis. Eye infections have been reduced through the use of baby shampoo eye washes. Residents with ongoing urinary incontinence are referred to specialists for review.</p> <p>Since July 2019, Radius Potter has reduced the incidence of urinary tract, skin, eye, fungal other infections such as ear, nose and throat significantly. In March 2019, the overall infection rate was 14 per 1000 beds. Since then the rate of all infections have continued to trend downwards with a rate in December 2019 of four. The infection rate has remained well below the radius median since August 2019.</p>

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End of the report.