

# Radius Residential Care Limited - Radius Elloughton Gardens

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## 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:

<b>Legal entity:</b>	Radius Residential Care Limited	
<b>Premises audited:</b>	Radius Elloughton Gardens	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 17 October 2019	End date: 18 October 2019
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	60	

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Radius Elloughton is part of the Radius Residential Care Group. Elloughton cares for up to 86 residents requiring hospital (medical and geriatric) and rest home level care. On the day of the audit there were 60 residents.

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 and staff.

A DHB Temporary Manager position was put in place in December 2018 to provide direction and oversight of the facility. The facility manager has been in the role for six months and has previous experience in aged care management. She is supported by an administrator, a clinical nurse manager who returned from parental leave in March 2019 and the Radius regional manager. Residents and family interviewed spoke positively about the service provided. The service has made a number of improvements since previous audit around staff education, communication and staffing ratios.

## 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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Discussions with families identified that they are fully informed of changes in health status. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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 is qualified and experienced for the role. 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 regularly, 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. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The registered nurses are responsible for each stage of service provision. Initial assessments, care plans and evaluations are completed by registered nurses within the required timeframes. Care plans and worklogs (developed on the electronic resident system) are written in a way that enables all staff to clearly follow their instructions. The general practitioner reviews residents at least three monthly. There is allied health professional involvement in the care of the residents.

The activity programme is varied and interesting and includes outings, entertainment and links with the community. Each resident has an individual leisure care plan. There are separate activity programmes for each unit with some integrated activities. The activities programme for residents with dementia is flexible and meaningful.

Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Medications are prescribed and administered in line with appropriate guidelines and regulations.

Meals and baking are prepared and cooked on-site. The menu is varied, appropriate and has been reviewed by a dietitian. Individual and special dietary needs are catered for. Alternative options are provided. There are nutritious snacks available 24 hours.

Registered nurses are responsible for care plan documentation. InterRAI assessments, electronic assessments and care plans have been developed and reviewed with input from residents and family within expected timeframes. Interventions guide staff in ensuring residents needs are met. Activities are appropriate to the residents assessed needs and abilities. Residents commented positively on the activities programme. Medications are managed in line with legislation and current regulations. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

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

Standards applicable to this service fully attained.

The building has a current building warrant of fitness.

A current building warrant of fitness is in place, reactive and preventative maintenance occurs. The facility provides space for residents to move around freely with mobility aids.

## 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.

Elloughton has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there was one resident with restraint and no residents using an enabler.

## 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.
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Elloughton has an infection control programme that complies with current best practice. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	0	41	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
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The service has a complaints policy that describes the management of the complaints process. There are complaints forms available at reception that provide links to HDC advocacy services. Information about complaints is provided on admission. Interviews with residents and families demonstrated an understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register that is held by the facility manager. Verbal and written complaints are documented. All complaints reviewed since January 2019 had noted investigation, timeframes, corrective actions when required and were signed off as resolved. Prior to this time there is evidence not all complaints were managed appropriately or escalated appropriately to senior company management. Results of complaints from 2019 are fed back to complainants and documented as being reported to staff. Complaints are trended at head office and shared with staff at a facility level. Fourteen complaints were received in 2018 and 17 complaints for 2019 year to date. All complaint responses lodged in 2019 were completed within the contractual timeframes in accordance with guidelines set forth by the Health and Disability Commissioner. A review of the complaints register evidences that the appropriate actions have been taken in the management and processing of these complaints.</p> <p>Of the complaints reviewed, three complaints are lodged with the HDC advocacy service (two in November 2018 and one in September 2019). The three HDC complaints remain open. The DHB placed the facility under DHB temporary management in December 2018 and the temporary manager recommendations around management and governance, clinical staffing, staff education, support and supervision, ongoing roster analysis and review, complaints processing and improved management communication with staff, residents and families. These</p>

		<p>recommendations are being implemented and monitored with regular reports from the temporary manager to the DHB. Specific initiatives implemented following complaints include employment of a new management team, upskilling of registered nurses and increased roster hours. Discussions with residents and families confirmed that recent issues are addressed, and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Five residents interviewed (three hospital and two rest home) stated they were welcomed on entry and were given time and explanation about the services and procedures. A sample of twelve incident reports reviewed, and associated resident files evidenced recording of family notification. Five hospital relatives interviewed confirmed they are notified of any changes in their family member's health status. The facility manager, clinical nurse manager, four registered nurses (RNs). and five healthcare assistants, two of whom work on AM and PM shifts were able to identify the processes that are in place to support family being kept informed.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement</p> <p>Family meetings are held, and newsletters distributed to ensure family have been informed of the DHB Temporary management process. A resident forum is held six weekly where residents are encouraged to raise concerns and are updated on progress and changes. Quarterly radius orbiter magazines are available to residents and families.</p> <p>Education on communication has been provided this year for all staff with an emphasis on English skills for those staff with English as a second language.</p> <p>The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Additional family meetings have been held to explain the role and progress of the temporary manager. Families are encouraged to visit and to talk with management.</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</p>	FA	<p>Elloughton is part of the Radius Residential Care group. The service provides rest home and hospital level care for up to 86 residents. On the day of the audit there were 60 residents. Fourteen residents were at rest home level care and 46 at hospital level care (including one ACC respite resident, one long term chronic health, one resident on a mental health contract and four residents receiving end of life care). All rooms are dual-purpose beds with two 21 bed wings (Grant Williams and Elizabeth) currently operating as hospital only. Elloughton Grange wing predominantly hospital level care and Mountain view predominantly rest home level care.</p> <p>Radius Elloughton has been under DHB temporary management since late December 2018. The temporary manager initially visited at least weekly and recently reduced visits to monthly. She continues to monitor the facility, providing guidance to the management team and the staff and submits update reports to the DHB. The facility was</p>

consumers.		<p>closed for new admissions initially for 12 weeks and has reopened with DHB and temporary manager approval.</p> <p>The Temporary Manager held resident and family focus group meetings January through to March 19. The Temporary Manager wrote to all residents and families to identify any further concerns or complaints. She continues to monitor the facility through focus group client.</p> <p>Radius has an overall business/strategic plan and Elloughton has a facility quality and risk management programme in place for the current year. The business plan includes business goals. Progress toward goals is regularly reported. The organisation has a philosophy of care which includes a mission statement.</p> <p>The facility manager commenced employment in April 2019 and is well trained and experienced in health management. She is supported by a clinical manager/registered nurse (RN), an administration coordinator and the Radius regional manager. The clinical manager returned from parental leave in March 2019 and has been in the role one year. The facility manager has completed in excess of eight hours of professional development in the past 12 months.</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 Elloughton. There is evidence that the quality system continues to be implemented at a level that meets the required standard. Interviews with six managers (facility manager, clinical manager, regional manager, eCase manager, administration coordinator and the temporary manager) and staff (five healthcare assistants, four RNs, one kitchen manager and one activities coordinator) confirmed that quality data is discussed at monthly staff meetings. Staff meetings include daily diamond meetings for the management team, weekly head of department meetings, monthly quality and monthly full staff meetings. Six weekly resident forums are held to listen to concerns and provide updates on improvement initiatives</p> <p>Discussions with the managers, and staff reflected staff involvement in quality and risk management processes. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which are utilised for service improvements. Quality data is benchmarked against other radius facilities at head office and results are communicated to management and then to staff in meetings and on staff noticeboards. Corrective action plans are documented, where results reflect opportunities for improvements. Corrective actions are signed off when implemented. Quality initiatives include an education project plan to increase skill and competencies of all staff with an emphasis on clinical competence for registered nurses. A strategic action plan covering clinical leadership, education and training, complaints management, effective communication has been implemented with progress reported monthly.</p> <p>Areas for improvement identified from the last family survey in Nov 2018 have been identified and form part of the strategic action plan. A staff survey from Aug 2019 shows improved staff satisfaction in all areas with positive comments arounds communication, teamwork. leadership, education and staff ratios.</p> <p>The service's policies are reviewed at national level by the clinical manager group with input from facility staff every</p>

		<p>two years. New/updated policies are sent from head office. Staff have access to manuals.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions are evaluated and signed off when completed.</p> <p>The service has a health and safety management system that meets current legislative requirements. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. All new staff and contractors undergo a health and safety orientation programme.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</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 accidents and incidents reporting policy. Accidents and near misses are investigated by the clinical manager and analysis of incident trends occurs. Incidents are included in the Radius key performance indicators (KPIs). There is a discussion of incidents/accidents at monthly staff meetings including actions to minimise recurrence. Clinical follow-up of residents is conducted by a registered nurse as confirmed on 12 incident reports sampled (ten hospital and two rest home). 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. Senior management were aware of the requirement to notify relevant authorities in relation to essential notifications. Six section 31 incident notification forms were completed in the past 12 months. The notifications related to two stage three pressure injuries (externally acquired), one unstageable pressure injury, one fracture, one absconding and one staffing issue. One death in 2018 was referred to the coroner.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	FA	<p>There are human resource management policies in place which includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. The service reports a high turnover of registered staff and difficulty attracting registered staff experienced in aged care in New Zealand. Eleven registered nurses are currently employed. Three RN's, the clinical manager and the facility manager are interRAI trained. Registered nurse</p>

processes are conducted in accordance with good employment practice and meet the requirements of legislation.		<p>staffing has improved recently with support from Radius head office.</p> <p>Six staff files were reviewed (one clinical manager, two RN's, two healthcare assistants and an activities coordinator) and evidenced that reference checks are completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. An annual in-service programme is provided with all compulsory sessions provided either annually or biannually. Additional training has been implemented this year including (but not limited to) ensuring clinical competence, communication, leadership, dementia and delirium, open disclosure and advocacy. Registered nurses have attended specific palliative care and wound management training. Specific training to meet requirements identified through the complaint process include skin care, wound management, continence and urinary tract infection management and falls and adverse event management. Annual competencies include medication, hand hygiene, restraint, wound management and moving and handling. Processes are in place to ensure all staff attend required education. Of the 46 health care assistants, 13 are level four or above, eight are level three and eleven are level two. All care staff are encouraged to achieve NZQA qualifications.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. There is a full-time facility manager and clinical nurse manager, who work from Monday to Friday and provide rotating on call cover. Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations within contractual timeframes. Staffing levels have been set by the temporary manager.</p> <p>The facility is split into four wings; the Elizabeth, William Grant, Mountain View and Elloughton Grange wings. Staff rostered in the Elloughton wing are available to assist and provide RN oversight to residents in the Mountain View wing. On night shift all units are staffed as one with two RNs and two HCA's.</p> <p>In the Elizabeth wing, there are 23 residents in total (all hospital level), there is one RN on duty on the morning and afternoon shifts. They are supported by four HCAs (three long and one short shift) on the morning shift and on the afternoon shift.</p> <p>In the William Grant wing, there are 18 residents in total (one rest home and 17 hospital level) there is one RN on duty on the morning and afternoon shifts. They are supported by four HCAs (two long and two short shifts) on the morning shift and on the afternoon shift.</p> <p>In the Elloughton wing there are nine residents in total (three rest home and six hospital) there is one RN on duty on the morning and afternoon shifts. They are supported by three HCAs (all long shift) on the morning shift and by three HCA's (all long shift) on the afternoon shift. On each shift the HCA's and RN are available to assist in Mountain view as required.</p> <p>In the Mountain View wing there are ten rest home level care residents with one HCA rostered on for the full shift morning and afternoon.</p>

		<p>Staff interviewed stated that overall the staffing levels are satisfactory and that the current managers provide good support. Call bell attendance reports identify an improvement in response times and there have been no complaints related to staffing or call bell response times since staffing levels were increased. Regular reports from the temporary manager to the DHB identify rostered staff hours are consistently above MOH recommendations. Interviews with residents and family members identify that staffing has improved over the last year and is adequate to meet the needs of residents.</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>Medication administration meets the guidelines for safe medicine management. The medication system is paper based. The RN on duty checks-in all medication on delivery. Registered nurses are responsible for the administration of medication have completed medication education and competencies. There were two rest home resident's self-medicating eyedrops, both had a competency in place, and this was reviewed three monthly by the GP. The eyedrops were stored appropriately in the residents' rooms. Standing orders are not used.</p> <p>Twelve paper-based medication charts were reviewed. Correct medication prescribing was evident in all charts reviewed. Inhalers and eyedrops are dated and are allocated to individual residents. The correct signing sheets are signed for following administration. Fridge temps are monitored and within range. Medication trolleys in the three nurses' stations were locked.</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>All meals at Elloughton Gardens are prepared and cooked on-site by a contracted food service company. The contracted provider employs sufficient kitchen staff to provide meal services over seven days a week. A current food control plan is in place.</p> <p>The food service company has a winter and summer menu, which has been reviewed by a dietitian. Food is plated in the main kitchen and transferred to resident dining areas by hot boxes. Food served on the day of audit was hot and well presented. The food service company are responsible for ensuring that all kitchen staff are trained in safe food handling and that food safety procedures were adhered to. Staff were observed assisting residents with their lunchtime meals and drinks. Diets are modified as required and likes and dislikes are catered to. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the registered nurses or clinical manager.</p> <p>Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service.</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 RN initiates a GP, NP or nurse specialist consultation or referral, for example to the dietitian, speech and language therapist. If external medical advice is required, this will be actioned by the GP. The RNs (including the clinical manager) and HCAs follow the detailed care plans and report progress against the care plan each shift.</p> <p>Staff have access to sufficient medical supplies (e.g., dressings). On the day of the audit there were two residents with a facility acquired pressure injury. (one stage 3, section 31 form had been completed, and one stage 2). Incident forms had been completed for the pressure injuries. pressure relieving equipment was in place for these residents, the wound care specialist had been involved with the stage 3 pressure injury. There were photographs taken at regular intervals to show the deterioration and then healing process. Both wounds were almost healed. Short term care plans were in place for all wounds. The chronic wounds (pressure injuries) had interventions documented in the long-term care plan.</p> <p>There were seven wounds on the day of the audit including solar keratosis, a lesion and superficial skin tears. Each wound had an individual assessment, management plan and the evaluation showed progress towards healing.</p> <p>Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>There was a suite of monitoring forms on the electronic system including (but not limited to) vital signs, blood sugar monitoring, falls risk, behaviour, social activity, food and fluid charts. Monitoring charts reviewed identified that these had been fully completed.</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>	FA	<p>There is a team of three activities coordinators at Elloughton Gardens. One full time activities coordinator is currently completing the diversional therapist course through Careerforce. One activities coordinator works two days a week and has level four Careerforce, and there is a casual activities coordinator who has a level four Careerforce qualification and is also an HCA.</p> <p>The residents each have a social, pastoral and life history assessment completed on admission with help from the family. A care plan is developed with resident centred goals which is reviewed at least six monthly. Participation records are maintained in the electronic system.</p> <p>There is a monthly planner developed for the facility, which is available to all residents, and a weekly copy is also printed for the residents.</p> <p>Activities for the younger residents are individualised according to their needs, and preferences. One younger resident has taken an interest in growing flowers for the facility with a group of male residents. Another younger resident attends a group outside of the facility on a weekly basis.</p> <p>There is a range of activities for residents to participate in including a weekly outing, regular entertainers, visits from</p>

		<p>the kindergarten, group games such as housie and bowls, a walking group, church services, weekly happy hour, and a daily resident's choice to finish off the afternoon. One on one sessions are provided for residents on a daily basis, this includes, (but not limited to) hand massages, chats, reading, walks, whatever the resident chooses. Other facilities visit to play games and meet up with the residents. An evaluation of each activity is maintained to include the positives and negatives voiced by the residents and suggestions for activities. This evaluation includes a list of the residents attended.</p> <p>Elloughton Gardens continue to build on their previous continuous improvement by continuing to celebrate special events such as 'loud shirt' day where all who chose to participate gave a gold coin donation to a charity of their choice. A Korean group visited the facility to provide a presentation of their culture, they wore traditional dress, sung songs and taught the residents how to say basic phrases in their language. The pet therapy, entertainers and BBQs continue to provide enjoyment for the residents. A resident choir has started with one resident singing following suffering from a stroke.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plan evaluations were completed on the electronic system for four long term resident files reviewed, (one hospital and one rest home level resident had not been admitted for six months). The short-term care plans, and the long-term care plans updated with changes. The care plan evidences when the reviews were completed and there is an additional note of changes identified and progression towards meeting goals.</p> <p>One hospital resident had not been at the service six months, for an evaluation of the long-term care plan. Care staff stated the RN involved them in the review of resident care plans. The GP completes three monthly medical reviews. Progress is evaluated against the resident goals with the long-term care plan amended for any changes to care. Relatives interviewed feel they are well informed of changes and are informed of resident reviews.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness expiring on 1 May 2020. Hot water temperatures are monitored randomly throughout the facility on a monthly basis, temperatures were all within expected ranges. External contractors continue to monitor the water supply monthly. All equipment has been tagged tested and calibrated recently. All communal areas are accessible to residents using mobility aids. The external areas are well maintained, accessible and have seating and shade provided.</p>
Standard 3.5:	FA	<p>The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory, skin and infections that do not require antibiotics. This</p>

Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		data is analysed, acted upon and reported to the facility meetings. Monthly data was seen in staff areas. The service submits data monthly to Radius head office where benchmarking is completed. There have been no outbreaks since the previous audits.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There was one resident using restraint with bed rails and a lap belt. There were no enablers in use. All necessary documentation is available in relation to the restraints. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.

## Specific results for criterion where corrective actions are required

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

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

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

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

No data to display
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End of the report.