

# Radius Residential Care Limited - Radius St Joans Care Centre

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## Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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 St Joans Care Centre
<b>Services audited:</b>	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 18 May 2021    End date: 19 May 2021
<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>	83



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Radius St Joan's is owned and operated by Radius Residential Care Limited. The service provides care for up to 98 residents requiring rest home, hospital, or residential disability level care (physical or intellectual). On the day of the audit, there were 83 residents.

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

A facility manager (registered nurse with experience in aged care management) manages the service and is supported by the clinical nurse manager. A Radius regional manager supports the management team. Residents and relatives interviewed spoke positively about the service provided.

The service has been awarded a continuous improvement for the physiotherapy programme.

This audit has identified areas for improvement around advance directives, initial assessments and initial care plans, and repairs to some surfaces.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents, including young people with disability, and families are informed regarding the Code and staff receive ongoing training about the Code. Personal privacy and values of residents are respected.

There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions that affect them. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends can visit residents at times that meet their needs. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

## 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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Services are planned, coordinated and are appropriate to the needs of the residents. A facility manager and clinical nurse manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and

risk management programme is embedded. Corrective actions are implemented and evaluated where opportunities for improvements are identified. Residents receive appropriate services from suitably qualified staff.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training are in place, which includes in-service education and competency assessments. In addition to topics relevant to the older person, topics relevant to young people with a disability are also addressed. Registered nursing cover is provided 24 hours a day, 7 days a week. 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.		Some standards applicable to this service partially attained and of low risk.
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The facility manager and clinical nurse manager manage entry to the service. There is comprehensive service information available. A registered nurse completes initial assessments. The registered nurses or enrolled nurses with registered nurse oversight complete care plans and evaluations within the required timeframe. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process.

Each resident has access to individual, group and small group activity programmes that meets the recreational needs of the residents.

Medication is managed 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 stored, prescribed, and

administered in line with appropriate guidelines and regulations. General practitioners review residents at least three-monthly or more frequently if needed.

Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options can be provided. Residents and relatives interviewed were complimentary about the food service.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy. There are an adequate number of communal showers and toilets. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are lounge and dining areas in the two wings of the facility. The internal areas can be ventilated and heated. The outdoor areas provide seating and shade.

There is an approved evacuation scheme and emergency supplies available. There is a minimum of one first aid trained staff member on every shift.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enabler. During the audit, there were no residents using restraints and one resident was using bedrails at night as an enabler. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidenced that 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.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	41	0	3	0	0	0
<b>Criteria</b>	1	89	0	3	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Radius St Joan's policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with three managers (the facility manager, clinical nurse manager and regional manager) and 22 staff (nine healthcare assistants (five from the AM shift and four from the PM shift); four registered nurses (RNs) which included one team leader; one enrolled nurse (EN); two activities coordinators, one kitchen manager, one laundry staff, one cleaner, one maintenance staff, one chaplain) and one contracted health professional (physiotherapist) confirmed their understanding of the Code and its application to their job role and responsibilities.</p> <p>Seven residents (four rest home including one young person on a disability (YPD) and two Māori residents; and three hospital level including one YPD and one Māori resident) interviewed confirmed that staff respect privacy and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent Consumers and where appropriate</p>	PA Low	<p>Informed consent processes are discussed with residents and families on admission. Written general consents were included in the admission process as sighted in 10 resident's files reviewed (six hospital including two YPD and four rest home including one YPD). Healthcare assistants (HCAs)</p>

<p>their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>interviewed confirmed consent is obtained when assisting with care.</p> <p>Advance directives sampled identified the resident resuscitation status and/or signed by the resident (if appropriate) or the general practitioner if medically indicated. In some records, family have signed an advance directive. Copies of enduring power of attorney (EPOA) were seen in the resident files as appropriate.</p> <p>Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Admission agreements were sighted for the long-term residents.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks. The chaplain, HCAs and activities staff interviewed all commented that they advocate on behalf of the residents.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Residents on the young persons with disability (YPD) contract are engaged in a range of community activities including (but not limited to) attending RSA, attending an external gym class, playing 500 cards socially, taking walks outside, and regular family visits.</p> <p>Relatives and friends are encouraged to be involved with the service and care. Key people involved in the resident's life are documented in the care plans. The service has strong community support, engagement, and participation. Residents and family stated that there was good communication during the Covid-19 pandemic that allowed them to see what their family members were doing during periods of lockdown and they had improved platforms to ensure that communication was maintained between residents, family, and staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood,</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints.</p> <p>An electronic complaints' register includes written and verbal complaints, dates and actions taken.</p>

<p>respected, and upheld.</p>		<p>Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). Nine complaints were received in 2020 and two complaints have been lodged in 2021 (year to date). Follow-up letters, investigation and outcomes are documented, evidenced in both complaints reviewed for 2021. Prompt and appropriate corrective actions have been implemented (e.g., staff performance management, disciplinary actions). There is evidence of lodged complaints being discussed in management and staff meetings.</p> <p>Two complaints have been lodged with HDC since the previous audit (May 2019). One complaint is now closed, and one remains open. The complaint that is closed was lodged in 2019 with corrective actions implemented around training of pharmacists, and staff training in relation to continence management, weight loss management and clinical observations (RN/EN only). A second complaint was lodged with HDC on 25 September 2020. This complaint was initially dealt with by the facility, with support from HDC advocacy, but the family have since lodged the complaint with HDC. All required correspondence has been forwarded to HDC within the timeframes required. Corrective actions implemented to date include a webinar presentation for staff addressing the care of complex residents and the deteriorating resident (29 October 2020); and a toolbox talk on 14 October 2020 in relation to pain management and clinical documentation.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There is an information pack given to prospective residents and families that includes information about the Code and the Nationwide Advocacy Service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code (in English and te reo Māori) are displayed throughout the facility. The facility manager or clinical nurse manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<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>	<p>FA</p>	<p>A tour of the premises confirmed there are areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect. An annual resident satisfaction survey was completed in September 2020 and the results indicated that most respondents reported overall resident experience as being good or very good; in particular, residents being made to feel welcome, the care delivered by the nursing staff, and satisfaction that staff ensure their rights/privacy and dignity are maintained. Residents and relatives interviewed confirmed that staff treat residents with respect. Residents interviewed confirmed their values and beliefs were considered. Interviews with HCAs described how choice is incorporated into resident cares. Young</p>

		people with disabilities are able to maintain their personal, gender, sexual, cultural, religious, and spiritual identity.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The Māori health plan for the organisation references local Māori health care providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Māori consultation is available through the documented iwi links and Māori staff.</p> <p>During the audit, there were nine residents that identified as Māori. One Māori resident file reviewed confirmed that Māori cultural values and beliefs are being met and are addressed in the Māori health care plan. This includes their tribal affiliations, and care plan strategies that linked to spiritual wellbeing (te taha wairua), mental wellbeing (te taha hinengaro) and physical wellbeing (te taha tinana). Residents are also assessed regarding tikanga for body parts, suggestions for de-escalation if required, restraint procedures and any special instructions regarding taonga.</p> <p>Three residents who identified as Māori were interviewed (two rest home and one hospital) and confirmed that their values and beliefs are being upheld by the service. Maori residents also attend Ra Awaawa Charitable Trust.</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, are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs.</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. Monthly staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of and adherence to professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an</p>	CI	<p>Policies and procedures align with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. An annual in-service</p>

<p>appropriate standard.</p>		<p>training programme is implemented as per the training plan. Two study days are allocated per year for education and training. Toolbox talks and annual staff competencies (e.g., manual handling, medication, syringe driver, first aid) complement the education programme.</p> <p>Outcomes for the service are monitored with benchmarking across all Radius facilities. Feedback is provided to staff via the various meetings and through graphs and notices on the noticeboard in the staffroom. There is a minimum of one RN on the night shift with additional RNs on the morning and afternoon shifts. A physiotherapist is available twelve hours a week. The robust and dynamic physiotherapy programme has close links with the activities programme and has resulted in a rating of continuous improvement. Registered nurses and HCAs were described by residents and family as being caring.</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>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All incident reports reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. One Chinese speaking resident has translation cards in her room to assist staff. In addition, family members assist; one staff is fluent in Mandarin; and Google translate is also being utilised. Young people with disabilities who are able to use information technology devices (e.g., computers, iPads, and mobile phones) have these devices available to them.</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 St Joan's is part of the Radius Residential Care group. The service provides rest home, hospital (geriatric and medical) and residential disability (physical and intellectual) levels of care. On the day of the audit there were 83 residents including 39 rest home level residents and 44 hospital level residents. Six residents (one rest home and five hospital) were under the young person with a disability (YPD) physical or intellectual contracts; two residents were on ACC (one rest home and one hospital); one rest home resident was on a (short-term) carer support contract; one rest home resident was on respite, and the remaining residents were on the age-related residential care contract (ARRC).</p> <p>There is an overarching Radius business plan for the organisation that includes a mission statement and values for the organisation. Radius St Joan's has a site-specific business plan 2020-2021 that reflects a person/family-centred approach. Objectives are reviewed regularly and are documented on the annual planner.</p> <p>The facility manager (registered nurse) has been in the role since July 2018. She was employed as the St Joan's clinical nurse manager for one year prior to becoming the facility manager. She is</p>

		supported by a clinical nurse manager, who has been in the role since August 2018. The regional manager (also a registered nurse) was present during the days of the audit and oversees the operations of four Radius facilities.
<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	The clinical nurse manager covers during the temporary absence of the facility manager. The regional manager is also available for support.
<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>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the managers, staff and residents including young persons with a disability confirmed their involvement in quality and risk management processes. Resident meetings are bi-monthly. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. Survey results reflect increased overall satisfaction when compared with 2019 results (link 1.1.8.1).</p> <p>The service has policies and procedures and associated implementation systems to provide an appropriate 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. Clinical guidelines are in place to assist care staff. The quality monitoring programme is designed to monitor contractual and standards compliance. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflected actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. The health and safety officer interviewed (clinical lead/RN) confirmed his understanding of Radius health and safety processes. He has completed external health and safety training along with two other health and safety representatives. Risk management, hazard control and emergency policies and procedures are in place. Staff begin their health and safety training during their orientation to the service. This is repeated every year. External contractors are also required to complete an annual health and safety induction programme (sighted). The facility manager monitors staff incidents on a weekly and monthly basis. These incidents are discussed during the quality staff meetings. Trends</p>

		<p>are identified and appropriate training or upskilling from staff occurs when a trend has been identified. Safety education was provided to staff in the October 2020 education programme.</p> <p>Falls prevention strategies are in place including intentional rounding; sensor mats; post falls reviews; and individual interventions.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. A review of 15 incident/accident forms (unwitnessed falls, skin tears, pressure injury, bruise, abrasion, challenging behaviour) identified that forms are fully completed and include follow-up by a RN. Neurological observations are carried out for any suspected injury to the head as per Radius protocol.</p> <p>The facility manager identified situations that were reported to statutory authorities since the previous audit including one physical assault.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></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 cover recruitment, selection, orientation, and staff training and development. Nine staff files reviewed (one clinical nurse manager, one clinical team leader/RN, one cleaner, one maintenance, one activities coordinator, four HCAs) provided evidence of reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals. A register of RN staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. Staff are required to complete written core competencies during their induction. These competencies are repeated annually. There is an implemented annual education and training plan that exceeds eight hours annually. Beginning in February 2021, staff have been attending a two-day training programme that covers mandatory topics; education relevant to young people with physical/intellectual disabilities (e.g., sexuality and intimacy, privacy, and advocacy; and topics of interest/relevance to the resident population (e.g., Huntington's disease). Groups are kept to no more than seven-eight participants. At the time of the audit, 29 of 71 staff had attended this two-day training that is scheduled to be repeated for all staff each year.</p> <p>There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. Six of eleven RNs (including the facility manager) have completed their interRAI training. Thirty-seven HCAs are</p>

		<p>employed. Twelve HCAs have completed a level four Careerforce qualification (or its equivalent), five have completed a level three qualification and six have completed a level two qualification.</p> <p>Staff have had training around Covid-19 including training around the transmission of the disease, safety precautions, isolation, and use of personal protective equipment.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Residents and family members interviewed reported there are sufficient staff on duty. There is a full-time facility manager and clinical nurse manager who work from Monday to Friday and provide on-call cover.</p> <p>The rest home only wing (31 beds) had 27 rest home residents on the day of audit including one YPD. There is an RN on duty in the rest home four days a week. There are three long (seven-eight hour) HCAs on the morning shift, three HCAs on afternoon shift (one long shift and two short shift (1500 – 1730 and 1500 – 2100) and one HCA on night shift.</p> <p>There are five wings designated dual purpose.</p> <p>The first two wings; Jebson (two rest home and 13 hospital including three YPD) and Doris (four rest home and sixteen hospital) are located adjacent to each other and are staffed with two RNs on the AM shift (or one RN and one EN), one RN on the PM shift. And one RN on the night shift (to cover the entire facility). There are four long and two short shift (0700 – 1300 and 0700 – 1100) HCAs to cover these two wings on the AM shift, two long and two short shifts (1500 – 2100) to cover the PM shift and one HCA to cover the night shift.</p> <p>The remaining three dual purpose wings are in close proximity to each other: Laura (one rest home and seven hospital including one YPD); Norman (six hospital); Charlotte (four hospital including one YPD). These three wings are staffed with one RN on the AM and PM shifts. Three HCAs (two long and one short 0700 – 1300) cover the AM shift, three HCAs (one long and two short (1500 – 2100 and 1500 – 1730) cover the PM shift and one HCA covers the night shift.</p> <p>Activities staff covers six days a week. There are designated cleaning and laundry staff seven days a week.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and</p>	<p>FA</p>	<p>The resident files 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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access.</p>

accessible when required.		
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager/clinical nurse manager/registered nurse (RN) screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager.</p> <p>The admission agreement form in use aligns with the requirements of the Age-Related Care contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Registered nurses, the enrolled nurse and senior healthcare assistants are responsible for the administration of medications and they complete an annual medication competency and attend medication education annually.</p> <p>Medication prescribed is signed as administered on the pharmacy generated signing chart. The facility uses a robotic sachet system for regular medications and blister packs for 'as required' medications. The RN on duty reconciles the delivery and documents this on the signing sheet. There were two residents self-administering medications on the day of audit, and both had a current assessment confirming their ability to manage medications.</p> <p>Standing orders are not used. There are no vaccines on site. Stock medications are reconciled with regular checks in place. Medical practitioners write medication charts correctly and there was evidence of one to three monthly reviews by the GP. All 20 medication charts reviewed had photo identification and allergy status identified.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service employs a Monday to Friday qualified kitchen manager, two assistant cooks and nine kitchenhands. Kitchenhands support the cooks. All staff have attended food safety hygiene training and chemical safety. A food safety plan was signed off by the Ministry of Primary Industries with the expiry date 31 March 2022.</p> <p>There is a fully functional kitchen, and all meals and baking is prepared and cooked on site. A food services manual is in place to guide staff. The cooks follow a rotating seasonal menu, which has been reviewed by the company dietitian. All recipes are readily accessible through the organisational intranet. Meals are served directly to residents in the main dining room from the kitchen and they are delivered in hot boxes to the other dining areas. A resident nutritional profile is developed for each resident on admission and is provided to the kitchen staff. The kitchen manager (interviewed) is notified of any dietary changes on a specific form which is signed by the kitchen manager once sighted (documented in every file sampled). Resident likes, dislikes, dietary preferences, modified and special diets are accommodated. There is special equipment available for residents if required. These are documented for each area on a clipboard in the kitchen and were noted to include allergies for a short stay resident.</p> <p>The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. All food is stored appropriately and dated. Residents and the family members interviewed were satisfied with the quality and variety of food served.</p> <p>The kitchen includes areas to be repaired (e.g., a concrete plinth that is difficult to clean without paint coming off, and bare areas of particle board in the pantry). Corrective action plans have been developed to address each area identified in the audit (link 1.4.2.4).</p> <p>The activities team and kitchen teams have collaborated to provide a monthly breakfast club that exceeds the required standard.</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>	<p>FA</p>	<p>The service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p>	<p>FA</p>	<p>All appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. Appropriate electronic assessment tools including</p>

<p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>interRAI assessments for residents under the ARCC are generally completed in a timely manner (link 1.3.3.3). Assessments are completed prior for each domain of the care plan. These assessments are well documented with key domains (e.g., dietary needs, mobility, risk of pressure injuries etc) started being documented as soon as the resident is admitted to the service. Assessments were reviewed at least six-monthly or when there was a change to a resident's health condition in files sampled. Care plans are developed based on the outcomes of assessments.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long-term care plans reviewed described in detail, the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. The record for a resident using respite care and the resident admitted for carer support had a short stay care plan documented. Residents and their family/whānau are involved in the care planning and review process with their engagement confirmed on the case conference notes of the electronic care planning document. Short-term care plans are in use for changes in health status (e.g., for urinary tract infections, skin conditions, bruising). Staff interviewed reported they found the plans easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Registered nurses (RNs), the enrolled nurse and healthcare assistants follow the detailed and regularly updated care plans and report progress against the care plan each shift. When a resident's condition changes, the RN initiates a GP consultation as confirmed by the GP and clinical nurse manager, or specialist consultation. If external medical advice is required, this will be actioned by the GP. The GP reported a high standard of care for the residents they work with.</p> <p>Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence, wound and pain advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring and wound management plans are in place for residents with 32 wounds (one pressure injury grade two, one resident with chronic skin condition, two with surgical wounds and all others with a skin tear, scratch or graze) with all being appropriately managed. The service is proactive about wound management with leadership provided by the clinical nurse manager to address any identified wound immediately. Five of the residents are being seen by the wound nurse specialist, two by a podiatrist and two have been referred to hospital for further assessment and/or treatment.</p> <p>Care plan interventions including intentional rounding, monitoring of weight, and food and fluid charts, demonstrated interventions to meet residents' needs.</p>

<p><b>Standard 1.3.7: Planned Activities</b></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>FA</p>	<p>There are two activities coordinators with one identified as the team leader. The team leader has been in the role for eight years and the other activities coordinator has been in the role for six months. Exercise sessions are provided in a variety of forms to maintain interest and physical well-being for all groups of residents. Time is allocated for one-on-one time for hospital residents and for those who choose not to participate in the group activities. Activities and entertainment occur in the main lounge and the smaller lounges. Group activities reflect ordinary patterns of life such as baking, library books, board games, bowls, current affairs and arts and crafts. Outings into the community, to concerts and places of interest are planned. Special events are celebrated.</p> <p>All long-term resident files sampled have a recent activity plan within the care plan and this is evaluated at least six-monthly when the care plan is evaluated. Residents and families interviewed commented positively on the activity programme. Residents and families provide feedback on the activities through surveys, resident meetings, and the six-monthly MDT reviews.</p> <p>Young residents with a disability are encouraged and supported to engage in one-on-one time and individual activities in the community with many attending social clubs. Van outings are planned more regularly for the younger people with disabilities. Some activities are provided specifically for this group. Exercise programmes are focused on the individual's preference in consultation with the physiotherapist.</p> <p>The service has had Wi-Fi and ultra-fast broadband installed and this service is available to residents. Residents including younger residents use this service to access emails and social media.</p> <p>Residents and family interviewed described a varied and interesting activities programme that was constantly reviewed to meet the current needs and interests of residents.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. In long-term files reviewed, the long-term care plan was evaluated at least six-monthly or earlier if there is a change in health status. A multidisciplinary review had been completed annually for all long-term resident files sampled that included input from the multidisciplinary team, including the resident and/or a family member. In files sampled, all changes in health status were documented and followed up. An RN signs care plan reviews. Short-term care plans sampled were evaluated regularly (at least every three days) and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files reviewed. Short-term care plans sighted included issues such as bruising, infections, skin tears and behaviour management. Where progress is different from expected, the service responds by initiating 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>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed, and the resident reassessed. In files reviewed, examples of close liaison with dietitians, physiotherapist, mental health staff and hospice was evident. A communication form is used whenever a resident visits a specialist or external provider (including GPs other than the contracted GPs) to document the purpose of the visit, any changes required and the timeframe for the next review. These forms were completed in files sampled.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were stored safely throughout the facility. Safety datasheets are available. The sluice rooms have personal protective clothing readily available.</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>	PA Low	<p>The building has a current building warrant of fitness that expires 1 December 2021. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. The facility is well maintained except for a communal toilet in the rest home wing and areas that require repair and resurfacing in the kitchen.</p> <p>All medical and electrical equipment was serviced and/or calibrated last in November 2020. Essential contractors are available 24 hours. Hot water temperatures are monitored monthly and are maintained below 45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. Residents have access to external areas that have seating and shade. There is an outdoor designated resident smoking area. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>The service has plans in place in case rooms are required for isolation in the event of an outbreak.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are an adequate number of communal toilets and shower/bathing areas for residents (link 1.4.2.4). Rooms in two wings have individual ensuites. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids, including those required by hospital level and residential disability level care residents. Residents are encouraged to personalise their bedrooms. Electric beds and ultra-low beds are used for hospital residents and residential disability residents as assessed.</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>The building has several small and large lounge areas including a main lounge in the rest home and a lounge for each of the Charlotte, Laura and Norman hospital wings and a large, combined lounge and dining area for the Jenson and Doris wings (all hospital level). There is also a main large dining area. There is safe and easy access to communal areas.</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 including personal clothing is laundered on site. There is a large laundry area with facilities. There are clear clean and dirty areas including an entrance for dirty laundry and an exit for clean laundry, a sluice tub and commercial washing machines with a sluice cycle if needed and driers. The laundry is staffed seven days per week. The laundry staff interviewed described how they would manage any infectious laundry, and this was as per policy and protocols.</p> <p>The cleaner interviewed identified that they have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness and laundry service in the facility. The cleaners' trolley was well equipped and stored in designated locked rooms when not in use. The two cleaners observed on the day of audit were seen keeping their trolley</p>

		in sight at all times.
<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 is a comprehensive, facility-specific emergency management plan to guide staff in managing emergencies and disasters including a potential Covid-19 outbreak in the facility. The services emergency management plan considers the special needs of young people with disabilities in an emergency. Training to all staff is provided as part of the orientation programme and it is compulsory for staff to attend an annual update. There is a minimum of one first aid trained staff member on every shift. The facility has an approved fire evacuation plan. Fire evacuation drills take place every six months.</p> <p>A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and ongoing training. Civil defence bins/supplies, stored in three separate areas, are checked six-monthly. There is sufficient water stored for three litres per day for a minimum of seven days per resident. Water is checked annually, and water sterilisation instructions are available. There are alternative cooking facilities available with a gas barbeque and gas hobs in the kitchen.</p> <p>Electronic call bells were evident in resident's rooms, lounge areas and toilets/bathrooms. The facility is locked at night with doorbell access that is linked to the nurse call system. The service has external security cameras in place 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 that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and all resident rooms are appropriately heated with panel heaters or heat pumps and a climate control system in the newer areas of the facility. Heating is adjustable in the resident's rooms. The facility is well ventilated when required. All rooms have external windows that open allowing plenty of natural sunlight.</p> <p>A boiler heats the water for the panel heaters with a certificate of compliance sighted on the day of audit.</p>
<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</p>	FA	<p>Radius St Joan's has an established 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. A registered nurse is the designated infection control nurse with support from the facility manager and the Quality Management Committee (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on</p>

be appropriate to the size and scope of the service.		orientation. The Radius infection control programme was last reviewed in April 2020.
<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	A registered nurse at Radius St Joan's is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the quality management team and care staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<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	There are Radius infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed</p>	FA	Infection surveillance is an integral part of the infection control programme and is described in Radius' infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and

<p>objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually and is provided to Radius head office. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality meetings and staff meetings and plans and interventions resulting from surveillance create improvements. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There have not been any outbreaks since the last audit.</p> <p>The service has more than two weeks supply of personal protective equipment in the event of an outbreak. Hand sanitisers are appropriately placed throughout the facility. Covid sign in and declarations are mandatory for visitors and contractors. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine.</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>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. During the audit, there were no residents using restraints and one resident was using an enabler (bed rails during night-time). This resident file was reviewed. Voluntary consent and an assessment process were completed. The enabler is linked to the resident's care plan and is regularly reviewed. Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	PA Low	Advance directives reviewed identified the resident resuscitation status as either for resuscitation or not for resuscitation. While there were seven advance directives signed by the resident or the GP if medically indicated, three were signed by the family member.	Three advance directives were signed by family members and not by the resident.	Ensure that advance directives are signed by the resident or by a GP if the resident is not competent with the decision noted as clinically indicated.  90 days
Criterion 1.3.3.3 Each stage of service provision (assessment,	PA Low	All resident documentation is recorded using an electronic system. There is a form to complete for the initial assessment and care plan. Four of the resident records reviewed included an initial assessment and care plan completed in a timely manner.	Five of the resident records reviewed were for residents who had entered the service since	Complete all initial assessments and initial care plans within 24 hours of

<p>planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>Eight records did not include an initial assessment and care plan completed in a timely manner noting that three of the eight residents entered the service prior to 2018, one in July 2020 and four in 2021.</p>	<p>the last audit and the initial assessments and care plans were not completed within 24 hours of admission.</p>	<p>admission.  180 days</p>
<p>Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>There is a planned maintenance schedule that addresses ongoing refurbishment and upgrades of the building. There is also reactive response to maintenance as issues and concerns are raised.  There are corrective action plans in place to address issues identified in the rest home wing in the communal toilet (e.g., bare areas on particle board and areas around the base of toilets that are not able to be properly cleaned). The kitchen also includes areas to be repaired (e.g., a concrete plinth that is difficult to clean without paint coming off, and bare areas of particle board in the pantry). Corrective action plans have been developed to address each area identified in the audit.</p>	<p>There are areas in the communal toilet in the rest home wing and areas in the kitchen that require repair.</p>	<p>Address areas in the rest home communal toilet area and in the kitchen that require repair and resurfacing.  90 days</p>

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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Examples of good practice were evident during this two-day certification audit. One example in particular reflects links between the physiotherapy programme and activities programme and has resulted in a rating of continuous improvement.</p>	<p>The physiotherapy programme is based out of a dedicated physiotherapy room that is easily accessible and is outfitted with a range of therapeutic exercise equipment including parallel bars, exercise gym equipment and an extra wide treatment table. Twelve hours are dedicated to physiotherapy services, split over two days per week. On admission, each resident is assessed by a physiotherapist for mobility, transfers, balance, and strength. A traffic light mobility chart is a means of communicating the residents' mobility and transfer needs to staff. Mobility and transfer assessment are completed electronically using eCase that are reviewed by the physiotherapist six monthly.</p> <p>At the time of the audit, 50% of the residents (rest home and hospital level) were actively involved in a physiotherapy rehabilitation programme. These rehabilitation programmes are led by either the physiotherapist, and/or activities staff and include a circuit training programme, a chair exercise group, strength and balance exercise classes and strength classes. Each class has defined entry criteria based on the resident's functional abilities. Positive outcomes have been measured via interviews with very satisfied residents and noted improvements in the resident satisfaction scores with a 35% increase in resident engagement.</p>

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End of the report.