

Radius Residential Care Limited - Radius Fulton Care Centre

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Radius Residential Care Limited

Premises audited: Radius Fulton Care Centre

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 30 October 2017 End date: 31 October 2017

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 90

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

| Indicator | Description | Definition |
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|  | 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 |
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| | 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 Fulton Care is owned and operated by Radius Residential Care Limited and cares for up to 93 residents requiring rest home, dementia or hospital (medical or geriatric) level care. On the day of the audit, there were 90 residents.

This surveillance audit was conducted against a subset of 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 and management.

The service is managed by a facility manager who is well qualified and experienced for the role. The facility manager is supported by a clinical manager and the Radius regional manager. At the time of the audit the clinical manager was on maternity leave, working only a few hours each week and an experienced relieving clinical manager was filling the role.

Residents, relatives and the GP interviewed spoke positively about the service provided.

This audit has identified no areas for improvement. The service continues to exceed the required standard around use of infection control surveillance data.

Consumer rights

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| 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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The service maintains a culture of open disclosure and families and residents are kept informed and updated, including when a resident has a change in health or an incident. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

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| 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 quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities, including Radius key performance indicators (KPIs), are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings have been held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. A comprehensive education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

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| 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' complete assessments, care plans and evaluations using the e-case electronic system. Residents/relatives are involved in planning and evaluating care. Risk assessment tools including the interRAI assessment tool and monitoring forms are included on this system and implemented and are used to assess the level of risk and support required for residents. Service delivery plans demonstrate service integration. Short-term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated.

The activities team provide an activities programme that involves the wider community. Each resident has an individualised plan and activities are scheduled across the week.

The medication management system follows recognised standards and guidelines for safe medicine management practice. Staff complete competency assessments.


Meals are prepared on-site by a contracted company. Individual and special dietary needs are catered for. Residents interviewed responded favourably regarding the food that was provided.

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Standards applicable to this service fully attained. |
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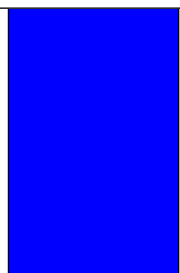
Radius Fulton Care has a current building warrant of fitness.

Restraint minimisation and safe practice

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| 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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Radius Fulton Care 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 were four hospital residents with restraint and seven residents with enablers.

Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | All standards applicable to this service fully attained with some standards exceeded. |
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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) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 1 | 15 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 1 | 38 | 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 |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>A complaints policy and procedures are in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception. A review of the complaints register evidences that the appropriate actions have been taken in the management and processing of complaints. One complainant was unhappy with the outcome, so the complaint was escalated to the regional manager to ensure every possible action had been taken before closing the complaint. A complaints procedure is provided to residents within the information pack at entry.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p> | FA | <p>Residents interviewed (six rest home and four hospital) stated they were welcomed on entry and were given time and explanation about the services and procedures. A sample of incident reports reviewed, and associated resident files evidenced recording of family notification. Relatives interviewed (one hospital and two dementia) confirmed they are notified of any changes in their family member's health status. The facility manager and registered nurses (who work across all areas) 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</p> |

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| <p>conducive to effective communication.</p> | | <p>they have to pay for that are not covered by the agreement. 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. Families are encouraged to visit.</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>Fulton Care is part of the Radius Residential Care group. The service provides rest home, dementia and hospital (geriatric and medical) level care. On the day of the audit, there were 22 rest home (including one resident funded by ACC), 19 (of a potential 19) residents in the dementia unit (all under the ARRC and 49 hospital level (including two younger persons with disabilities (YPD), one resident on a long-term support – chronic health conditions (LTS-CHC) contract and one resident funded by ACC) residents. There are 18 dual-purpose beds.</p> <p>The facility manager has been in the role for the past 15 years. The clinical manager (RN) has been in the role for three years, having previously been a clinical manager at another Radius facility. The clinical manager was on maternity leave at the time of the audit, although had continued to work one day per week to support the relieving clinical manager. Both the clinical and relieving clinical managers were present during the audit. The facility manager reports to an operations manager and a weekly report has been provided.</p> <p>Radius has an overall business/strategic plan and Fulton Care has a facility quality and risk management programme in place for the current year and the goals have been reviewed regularly. The organisation has a philosophy of care, which includes a mission statement.</p> <p>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> | <p>FA</p> | <p>There is an organisational business/strategic plan that includes quality goals and risk management plans for Fulton Care. There is evidence that the quality system continues to be implemented at Fulton Care. Interviews with staff (registered nurses, four caregivers – two from the hospital and one each from the rest home and dementia unit, the diversional therapist and the activities coordinator) confirmed that quality data is discussed at monthly staff meetings. The clinical manager and the facility manager advised that they are responsible for providing oversight of the quality programme. There is also a monthly quality meeting where all quality data and indicators are discussed. Minutes of these meetings are available to all staff. The quality and risk management programme are designed to monitor contractual and standards compliance. The service's policies are reviewed at national level by the operations management team, with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals. A weekly report is provided to the operations manager and monthly data is collated in relation to Radius key performance indicators (KPI). Resident/relative meetings are held. Restraint and enabler use is reported within the quality management meetings.</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. The service has a health</p> |

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| | | and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies are implemented for individual residents and staff receives 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. The May 2017 survey showed that 82% of respondents would recommend the facility to others. The survey outcomes were very close to the high ratings achieved at the previous survey. |
| <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. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. Incidents are included in the Radius KPIs. Fourteen incident forms sampled demonstrated appropriate clinical follow-up of incidents. There is a discussion of incidents/accidents at monthly staff meetings including actions to minimise recurrence. A registered nurse conducts clinical follow-up of residents. Discussions with the facility manager and regional management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A section 31 notification was made following a potentially serious medication error and two pressure injuries. Public Health were notified of a norovirus outbreak in April 2017 and an influenza outbreak in August 2016.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | FA | <p>There are human resource management policies in place, where the recruitment and staff selection processes require that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Six staff files were reviewed (the relieving clinical manager, two healthcare assistants, a cleaner, the activities coordinator and one registered nurse) and there was evidence 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. The in-service education programme for 2016 was fully completed and a plan for 2017 is being implemented. Healthcare assistants have completed an aged care education programme. Seventeen healthcare assistants work in the dementia unit and all have completed the required NZQA standards, as has the activities coordinator. The registered nurses are able to attend external training including sessions provided by the local DHB. Annual staff appraisals were evident in all staff files reviewed.</p> |

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| <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>Radius policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. At least one registered nurse and two healthcare assistants are rostered on at any one time. Advised that extra staff can be called on for increased resident requirements and the roster. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</p> <p>The roster is as follows:</p> <p>The clinical manager and facility manager each work 40 hours per week and both are on call at all times.</p> <p>Hospital: There are two wings in the hospital. On morning shift and afternoon shift there are two registered nurses across the two wings and there is one registered nurse overnight.</p> <p>One wing had 19 hospital level and three rest home residents at the time of the audit. There are two healthcare assistants on a full morning shift, one from 7am to 1pm and one from 8am to 1pm. On afternoon shift two healthcare assistants work a full shift and one works from 5pm to 10pm.</p> <p>The second hospital wing had 20 hospital level and two rest home level residents at the time of the audit. There are two healthcare assistants on a full morning shift and one from 7am to 12pm. On afternoon shift two healthcare assistants work the full shift, one works from 4pm to 8pm and another from 4pm to 9pm.</p> <p>In the 'rest home' there were eight hospital level residents and 17 rest home level residents. One registered nurse works a morning shift to cover the rest home and dementia units, seven days per week. Two healthcare assistants work a full morning shift. On afternoon shift one healthcare assistants work the full shift, one works from 4.30 to 8.30 and another works from 5.30 to 8.30.</p> <p>Overnight three healthcare assistants support the registered nurse across the rest home and hospital wings (which are all closely located).</p> <p>In the dementia unit (19 residents) two healthcare assistants work a full morning and afternoon shift and one overnight.</p> <p>A diversional therapist works from 9am to 5.30pm, Monday to Friday and another from 1pm to 7pm Saturday and Sunday. The activities coordinator works from 8am to 4.30pm, five days per week.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner</p> | <p>FA</p> | <p>The service uses individualised robotic packs. Medication charts have photo identification. The RN checks robotic pack medications on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are kept in locked medication rooms. Staff sign for the administration of medications on medication sheets held with the medicines. Medication files reviewed evidenced that all regular non-packaged medications were signed as administered. There were no expired medications in the medication storage areas. 'As required' medications (prn) had indications for use indicated.</p> |

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| <p>that complies with current legislative requirements and safe practice guidelines.</p> | | <p>RNs or senior healthcare assistants administer the medication. Annual medication competencies are completed. Three residents self-administer inhalers (two rest home and one hospital). Assessments, competency and reviews have been conducted at three-month reviews.</p> <p>The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. The medication fridge is monitored daily (records sighted). Medications are reviewed at least three monthly by the attending GP.</p> <p>One registered nurse was observed administering medications correctly. Resident photos and documented allergies, or nil known, were noted on the sample of 14 medication charts reviewed.</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>All meals at Radius Fulton are prepared and cooked on-site by a contracted food service company. The food service company operates the business from the commercial kitchen and provides meal service to a number of other aged care services and community colleges. The local council has certified the commercial kitchen. The food service company has a winter and summer menu, which has been reviewed by a dietitian. Meals are served directly to rest home, hospital and dementia residents via bain maries and tray service. 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>Snacks are supplied and available 24 hours per day in the dementia unit.</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</p> | <p>FA</p> | <p>Care plans sampled were current and interventions reflect the assessments conducted and the identified requirements of the residents. Interviews with clinical staff and relatives confirmed involvement of families in the care planning process. There was evidence of strong links and referrals to allied health professionals including the dietitian, the mental health team, the physiotherapist and hospital specialists.</p> <p>Wound assessment and wound management plans were documented in the electronic database for all types of wounds including skin tears and abrasions, lesions, surgical wounds, ulcers, gout areas, and pressure injuries. In the dementia unit there were four residents with wounds none with pressure injuries; for rest home residents there were four residents with wounds, plus two stage two pressure injuries (one sacral, one foot) and two stage one pressure injuries (one heel, one foot); there were 11 hospital residents with wounds, plus one resident with a stage</p> |

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| <p>desired outcomes.</p> | | <p>two pressure injury (lateral foot). All pressure injuries were facility acquired. Electronic documentation for all wounds included assessment, plans, progress notes and evaluations. Input has been sought from wound specialists and pressure area prevention methods included two hourly turns, and use of pressure relieving devices.</p> <p>Dressing supplies were available, and a treatment room was stocked for use.</p> <p>Contenance products were available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice was available as needed and this could be described by staff interviewed.</p> <p>Monitoring records sampled demonstrated that required interventions including weight management, frequent blood pressure recordings when requested by the doctor, intentional rounding, food and fluid monitoring and skin care regimes are implemented.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>There are three members of the activities team including two diversional therapists and one activity coordinators. One activities coordinator provides activities in the rest home and hospital and one diversional therapist organises activities in the dementia unit. The diversional therapist works across both areas. There is a separate programme delivered for rest home/hospital and dementia residents. The dementia unit programme is run over seven days. All three activity coordinators have completed dementia training. Care staff in the dementia unit have access to equipment and provide a variety of activities when the activities staff are not present. The activities programme is able to cater for the needs of all levels of care provided at Radius Fulton Care.</p> <p>On the day of audit, residents were observed being actively involved with a variety of activities in the hospital, rest home and the dementia unit. The programme is developed weekly and displayed in large print. All residents are given a weekly plan. Residents have an activities/social profile assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career, and family. A plan documenting appropriate activities to support behaviour management had been completed for dementia residents.</p> <p>The programme observed in the dementia unit was appropriate for people with cognition and memory impairments.</p> <p>Activities are age appropriate and are planned. There are several programmes running that are meaningful and reflect ordinary patterns of life. The programme is flexible and can be changed to reflect the residents needs on the day. There are also visits from community groups.</p> <p>Residents have featured in the newspaper recently for commemorating 100 years since the battle of Passchendaele, the residents set up a memorial with crosses and handmade poppies (made by the residents) outside the facility, and subsequently inspired some school children from Queenstown to complete a school project on the subject.</p> <p>The resident action group known as the 'rag timers' group have raised money through running quizzes, tombola's etc to fund the new resuscitation machine for the facility, and continue to fundraise to make up 'toilet bags'</p> |

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| | | <p>containing toothbrush, toothpaste, comb, razor face cloth shower gel shampoo etc for residents who arrive to the facility with nothing, or residents being admitted to hospital.</p> <p>Residents provide regular feedback around their likes and dislikes of the activity programme to the activity staff, through monthly resident meetings or following activities. There are regular outings. Resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed.</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 plans reviewed had been evaluated six monthly (for residents that had been at the service longer than six months) or when changes to care occurred by registered nurses. Evaluations were documented and included progress to meeting goals. There was documented evidence of care plans being updated as required. There is at least a three-monthly review by the medical practitioner.</p> <p>There are short-term care plans to focus on acute and short-term issues as evidenced in the files reviewed.</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 facility has a current building warrant of fitness that expires on 3 March 2018.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection</p> | CI | <p>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 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. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the acting facility manager. Two outbreaks since the previous audit have been appropriately managed. The service has exceeded the standard around use of infection control surveillance data.</p> |

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| control programme. | | |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were four hospital residents with restraint and seven residents with enablers. All necessary documentation has been completed in relation to the restraints and enablers. 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. Three files sampled demonstrated that enabler use is voluntary.</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.

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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 |
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| Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and | CI | The service collects infection control summary data for each unit, each month and this is analysed. The data is collated and sent to Radius Head Office where it is benchmarked against standardised data. Corrective action plans are developed and implemented if the service is above the KPI. Additionally, other areas where infections could be prevented or minimised by a change in practice and additional education are identified and a correction plan developed. | In August 2016 the service had an outbreak of influenza H3N2 strain that affected 24 residents and 10 staff. A corrective action plan was developed in response to issues identified as a result of the influenza outbreak debrief meeting and feedback from Public Health. The overall goal of the plan was prevention of the influenza virus, specifically with a goal of 95% compliance for residents in receiving influenza vaccine 2017 and more than 65% compliance for staff at Radius Fulton receiving the vaccine. The plan was twofold – the first aspect was to build on the clinical managers knowledge learnt from the previous outbreak. This has been achieved by self-directed learning around ensuring section 31 Reporting Notification to Ministry of Health in the event of an influenza outbreak going forward, continuing to contact Public Health South and IFC Southern DHB in the event of an outbreak, ensuring outbreak logs are confirmed as final to Public Health South in event of an influenza outbreak and ensuring residents’ over the age of 80 are included as priority one when using antiviral agents. The second aspect was to build on staff knowledge learnt as a result of the previous influenza virus outbreak. Following the attendance of all staff at the outbreak debrief meeting, further training on droplet precautions was provided for |

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| management in a timely manner. | | | all staff and more education on droplet precautions and the influenza outbreak policy and procedure was provided prior to the 2017 influenza season. Hand hygiene education was also provided. |
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End of the report.