

Radius Residential Care Limited - Radius Glaisdale

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 Glaisdale

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: 17 October 2019 End date: 17 October 2019

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 69

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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 Glaisdale is owned and operated by Radius Residential Care Limited. The service is certified to provide rest home, hospital, medical and dementia level of care for up to 80 residents. On the day of audit 69 residents.

The service is managed by a facility manager/registered nurse who has been in the role eight months and has previous experience as a clinical manager in aged care. He is supported by a Radius regional manager. There is a current vacancy for a clinical manager. Residents, relatives and the GP interviewed spoke positively about the service provided at Glaisdale.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and general practitioner.

All three shortfalls from their previous certification audit have been addressed regarding communication with relatives, care plan interventions and aspects of medicine management.

There were two findings identified at this surveillance audit around neurological observations and timeliness around initial interRAI assessments

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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There is open communication with residents and relatives which also includes open discussion around incidents. There are two monthly resident/relative meetings which provide an opportunity for suggestions and feedback on the services provided at Glaisdale. Information about the Code and related services is readily available to residents and families. Complaints processes are being implemented and complaints and concerns are managed and documented.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The facility manager is responsible for the day-to-day operations and is supported by a regional manager. The quality and risk management programme include service philosophy, goals and a quality planner. Quality activities, including Radius key performance indicators, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. There is an internal audit programme that is followed with any quality improvements identified and implemented. An education and training programme have been implemented with a current plan in place. An orientation programme is in place for new staff. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care. Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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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

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. At the time of the audit there were no residents with restraint and no residents using enablers. Staff receive regular education and training on restraint minimisation and challenging behaviours.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

Standardised definitions are used for the identification and classification of infection events. The infection control co-ordinator (facility manager) is responsible for the collation, analysis and trending of data. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	1	1	0	0
Criteria	0	41	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. A complaints procedure is provided to residents within the information pack at entry. Compliments, suggestions or complaints forms are available within the facility. There have been two complaints in 2018 and seven complaints in 2019 to date. The complaint register includes relevant information regarding the complaint. The complaints reviewed included acknowledgement, investigation, resolution and information provided regarding access to advocacy. The required timeframes for complaint management as determined by the Health and Disability Commissioner, had been met.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Residents (two rest home and two hospital) and two hospital level family members interviewed stated they were welcomed on entry and were given time and explanation about services and procedures. The relatives confirmed they are notified promptly of any changes in their relative's health status. Twenty-six incidents/accidents reviewed from the month of August 2019 evidenced relatives were notified within a timely manner. The previous finding around communication with family regarding falls has been addressed. Families are involved in the development and review of resident care plans. Resident and relative meetings are held two monthly. Quarterly newsletters keep residents and families updated on facility matters, services and feedback on survey results.</p> <p>The facility manager has an open-door policy. The service has policies and procedures available for access to</p>

conducive to effective communication.		interpreter services for residents (and their family/whānau).
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Radius Glaisdale is part of the Radius Residential Care group. The service currently provides rest home, hospital (and medical) and dementia levels of care for up to 80 residents. On the day of the audit there were 69 residents including 17 hospital level residents (including one respite and one resident under ACC), 32 rest home residents and 20 dementia level of care residents.</p> <p>There is an overarching Radius business plan 2018 – 2021. Radius Glaisdale has a site-specific business plan 2018 – 2019 that includes the mission statement. Objectives are reviewed quarterly and regularly and includes falls prevention, achieving all internal audits above 95% and staff recruitment and retention.</p> <p>The regional manager (registered nurse) oversees four Radius sites in Hamilton and is based at Glaisdale for up to two days a week. The facility manager provides monthly reports to the regional manager report.</p> <p>The facility manager has been in the role since February 2019. He has previous experience as a clinical manager at another facility. There has been a vacancy for a clinical manager since July 2019. The organisation has been actively recruiting for a replacement with an appointment in the near future. The facility manager and senior RN are covering the vacancy with support from the regional manager and managers from the other local sites. The DHB and HealthCERT were notified of the change of facility manager.</p> <p>The facility manager is a registered nurse with a current practicing and has completed orientation to the role including marketing, funding, business planning, risk management and ARC contracts. He also attended the three-day Radius managers conference covering human resources, DHB contracts and leadership.</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</p>	FA	<p>There is an organisational quality and risk management plan in place. Quality and risk performance are reported at the weekly hub (heads of department) meetings and staff meetings. The facility manager advised that he is responsible for providing oversight of the quality programme. There is daily triangle of support meetings (facility manager, senior RN (in the absence of a clinical nurse manager) and administration manager. There are monthly staff meetings that includes set agenda items of health and safety, infection control, audit outcomes, restraint and any concerns/complaints. All quality data, trends and analysis are documented in meetings minutes which are available to staff. Registered nurse meetings are held at least six weekly. Required actions and resolutions from facility meetings are documented.</p> <p>Annual resident/relative satisfaction surveys are completed annually in April with results communicated to residents, relatives and staff through meetings and newsletters. An upward trend of increased resident/relative satisfaction in meals and activities was identified. A separate food satisfaction survey in September 2019 demonstrated residents</p>

<p>improvement principles.</p>		<p>were satisfied with the meals.</p> <p>The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at national level every two years. Clinical guidelines are in place to assist care staff.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. Data is collected in relation to a variety of quality activities (accidents/incidents, pressure injuries staff incidents, infection control, hazards, compliments/complaints and internal audit outcomes). An internal audit schedule continues to be completed. Audits are delegated to the relevant personnel. The regional manager completes facility health checks. Corrective action reports and re-audits are required for any audit results less than 95%. Corrective actions or quality initiative plans are developed, evaluated and signed off when completed. Outcomes of internal audits are discussed at facility meetings.</p> <p>Risk management, hazard control and emergency policies and procedures are in place. Health and safety goals are included in the site-specific quality plan. Health and safety are an agenda topic at the facility meetings and staff have the opportunity to raise any health and safety concerns/issues. The service has a nominated health and safety representative who commenced the role in September 2019. She has completed a two-day health and safety course. Staff interviewed confirmed they are kept informed on health and safety matters and hazard management. There is a current hazard register.</p> <p>Falls prevention strategies are in place including regular resident checks, use of sensor mats, low beds, GP reviews to exclude medical causes, physiotherapy assessment. There is a quality improvement plan in place to reduce falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their</p>	<p>FA</p>	<p>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise incidents/accidents. Incidents are included in the Radius key performance indicators (KPI). Twenty-six incidents/accidents (falls, skins, bruise) entered into the electronic system for August 2019 identified timely notification of family, RN assessments, corrective actions and interventions; however, not all unwitnessed falls had neurological observations completed as per protocol (link 1.3.6.1). There is a discussion of incidents/accidents at the monthly staff/quality and clinical meetings including trends, analysis and actions to minimise recurrence.</p> <p>Discussions with the facility manager and regional manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no incidents or outbreaks to report.</p>

family/whānau of choice in an open manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and professional development. Six staff files reviewed (one facility manager, two RNs and three HCAs) included reference checking, signed employment contracts, job descriptions, completed orientation programmes and annual performance appraisals. A register of RN staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. Staff are required to complete written core competencies during their induction and complete an orientation handbook.</p> <p>There is an implemented annual education and training plan that covers mandatory requirements and exceeds eight hours annually. The service identified education attendance was low and have implemented (from July 2019) three training sessions that are to be held throughout the year requiring all staff to attend all sessions annually. Session 1 includes all topics relating to personal cares, session 2 relates to wellbeing and topic 3 is focused on health and safety. The same session is provided in the morning and the afternoons allowing staff on all shifts the opportunity to attend. Staff are rostered to attend. Other topical education is provided throughout the year. Staff complete competencies relevant to their roles including medication, syringe driver, food safety, restraint, and fire safety. Radius have two career force assessors.</p> <p>Five of nine RNs (including the facility manager) have completed their interRAI training. Registered nurses are supported to maintain their professional competency.</p> <p>There are 15 HCAs who work in the dementia care unit. Five have completed the dementia unit standards and six HCAs are progressing through the units. Four HCAs are newly employed and yet to register.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is an acuity and clinical staffing ratio policy in place that includes a documented rationale for staffing the service. The facility manager is a registered nurse, works full time and on-call. Additional support is also provided by a regional manager (Monday to Friday). Staffing is as follows: There are two RNs on the morning shift and two on the afternoon shift. One RN on each shift is allocated to oversee the dementia unit. There is one RN on night shift.</p> <p>In the 60-bed dual purpose unit), there were 49 residents on the day of audit (32 rest home and 17 hospital level residents). There are six HCAs on the morning shift – three on full shift and three finishing at 2pm. There are six HCAs on the afternoon shift – three on full shift, one finishing at 8.30pm and one from 2-6pm. There are two HCAs on night shift.</p>

		<p>Dementia unit – 20 beds: Currently 20 residents. There are two HCAs on the morning shift with one finishing at 2.30pm. There are two HCAs on afternoon shift with one finishing at 9pm. There is one HCA on night shift with other HCAs and the RN readily available.</p> <p>Staff interviewed stated that there is adequate staffing to manage their workload. When staff are absent and a replacement cannot be found from the current staff, agency staff are used. The service has developed a staffing action plan to follow for staff sickness.</p> <p>Residents interviewed confirmed that there are sufficient staff on-site at all times.</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>	<p>FA</p>	<p>Medication management policies and procedures comply with medication legislation and guidelines. Registered nurses and medication competent HCAs administer medications and have completed medication competencies and medication education. Medication administration was observed in the hospital and the dementia care unit. Administration practice was compliant against the administration policy. Medications are delivered in robotic rolls, and there is documented evidence that these have been checked against the medication chart. Each unit has a medication room. All medications were within the expiry date, and a process has been implemented to ensure that all expired medications are returned to the pharmacy. The medication fridges are monitored, and all temperatures were within the acceptable range. All eyedrops in use were dated on opening. There was one self-medicating rest home resident in the facility. A self-medicating assessment had been completed and the assessment was reviewed three monthly.</p> <p>Twelve medication charts (paper-based) were reviewed (four hospital, four rest home and four dementia care) and met prescribing requirements, the allergy status had been identified on all charts. As required medications had prescribed indications for use.</p> <p>The previous finding around medication reconciliation, expiry dates and allergy status has been addressed.</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</p>	<p>FA</p>	<p>There is a fully functional kitchen located within the service area of the building. All food and baking is prepared and cooked on-site by a contracted service. The chef/kitchen manager is a qualified chef. He is supported by a second chef and kitchen assistants who have all completed food safety training. The four weekly seasonal rotating menu has been reviewed by a dietitian. There are menu options for special diets and food preferences. The chef works with families on cultural preferences to ensure residents of different cultures have their dietary needs met. There is special equipment available for residents if required.</p> <p>Meals are cooked, put into a bain marie, plated up, transferred to a hot box, sealed for 20 minutes and then served. End-cooked temperatures and hot/cold box temperatures are monitored. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. The chef is notified of any changes to resident's</p>

<p>delivery.</p>		<p>dietary requirements. Protein supplement is added to porridge as required.</p> <p>The temperatures of refrigerators, freezers and chiller are monitored and recorded. The chemical provider checks and monitors the performance of the dishwasher. All food is stored appropriately and dated. A cleaning schedule is maintained. The current food control plan expires on 3 March 2020.</p> <p>Residents in the dementia service have access to snacks 24 hours. Residents and the family members interviewed commented positively about the quality and variety of food served.</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>Registered nurses develop the long-term support plan from information gathered over the first three weeks of admission. Resident care plans reviewed were resident-focused and individualised. Support needs as assessed including behaviour management plans (as appropriate) were included in the long-term care plans reviewed. The previous finding around care plan interventions has been addressed.</p> <p>Short-term care plans are used for changes to health status and were sighted in resident files, for example for infections and wounds. Short-term care plans have either been resolved or if ongoing, transferred to the long-term care plan.</p> <p>Long-term care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Files reviewed provided evidence of relative's involvement in the care planning process where appropriate. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist and dietitian. Care plans were amended to reflect changes in health status and were reviewed on a regular basis.</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>PA Moderate</p>	<p>Registered nurses (RNs) and HCAs follow the detailed and regularly updated care plans and report progress against the care requirements each shift. If a resident's health status changes the RN initiates a GP or nurse specialist review. Relatives interviewed state they are contacted for any changes in the resident's health.</p> <p>Wound assessment and care plans, wound review plans and evaluation notes were in place for residents with wounds. Wound documentation was complete.</p> <p>There were three hospital residents with pressure injuries (PI); one resident with two stage one pressure injuries and two stage two pressure injuries; one resident with two stage two pressure injuries; and one resident with one stage one pressure injury. In the rest home there was one resident with a stage one PI and one resident with a stage two PI. In the dementia service there was one resident with a stage two PI. There had been GP input for PIs. Four HCAs interviewed had received prevention of pressure injury education and there were adequate pressure relieving resources available. Other wounds being treated on the day of the audit included four surgical wounds; 13 skin tears; two skin conditions; four scrape / abrasions and one laceration.</p>

		<p>The service was aware of an increasing number of pressure injuries and focusing education and practice around pressure injury prevention.</p> <p>RNs (interviewed) have access to specialist nursing wound care management advice as required. Staff have access to sufficient medical supplies, dressings and continence products. Resident files include continence assessments and plans as required.</p> <p>Electronic monitoring forms are completed and reviewed, for example, turning charts, food and fluid charts, blood pressure, weight charts and behaviour charts. Neurological observations had not been completed as per protocol.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>A diversional therapy team leader has been in the role for two months and is employed nine hours per week and oversees the activity programme for the rest home, hospital and dementia care unit. There are three activities team staff who rotate across the rest home, hospital and dementia services. One activities staff member is employed 10 hours per week; one is employed 30 hours per week, and one is employed 20 hours per week. Healthcare assistants in the dementia unit incorporate activities for residents into their duty.</p> <p>The activity programmes include includes dancing, singing, music, board games, newspaper reading, arts, movies and happy hours. One-on-one time is spent with residents who choose not to or are unable to participate in group activities. There are regular exercise groups, walks, entertainment and van outings. Community visitors include volunteers, church services, the Salvation Army choir and band, and speakers. The activity programme for dementia care residents is flexible and focused on meaningful activities, small group activities and one-on-one time.</p> <p>All resident files reviewed have an individual recreational assessment and activity plan that is evaluated at least six monthly. Residents and families interviewed commented positively on the activity programme. Residents have the opportunity to feedback on the activity programme through resident meetings</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Six monthly evaluations of the plan of care had been evaluated. Written evaluations identify if the resident/relative goals are met or unmet. Short-term care plans sighted on eCase have been evaluated and resolved or added to the applicable long-term care plan if the problem is ongoing. There is at least a three-monthly review by the GP.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>The facility has a current building warrant of fitness that expires on 13 September 2020. The maintenance manager was interviewed and described hot water monitoring (records were sighted) and the reactive and preventive maintenance system. The facility has access to maintenance personnel after hours as required. The maintenance</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>management system is electronic. There are well kept garden areas with accessible outdoor spaces, seating and shade including a secure area for those in the dementia unit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme. The acting infection control coordinator/facility manager holds a recognised infection control qualification and is covering the role pending the appointment of a clinical manager. All infections are reported in the eCase system and a monthly report including end of month trends and analysis is generated. Data including corrective actions is discussed at the management and facility meetings. Corrective actions are implemented where upward trends are identified for infections. Meeting minutes and infection control data are displayed in the staff room. The service submits data monthly to Radius head office where benchmarking is completed.</p> <p>There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The service has documented systems in place to ensure restraint is minimised and only used as the last resort. On the day of audit, there were no residents with restraint and no residents using enablers. Staff training has been provided around restraint minimisation and challenging behaviours. Internal audits are completed and monitor compliance against the standard.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	Six files were reviewed. Initial assessments and an interim care plan had been developed by registered nurses within 24 hours of admission for all residents including the respite care resident. Two files reviewed (one respite care and one resident under ACC) did not require interRAI assessments. InterRAI assessments for three of the four long-term residents had not been completed within 21 days of admission. Electronic evaluations (multidisciplinary – MDT case conference) are completed at least six monthly	Three resident files (two dementia care and one rest home) reviewed did not have interRAI assessments completed within 21 days of admission.	<p>Ensure all initial interRAI assessments are completed within the required time frame.</p> <p>90 days</p>
Criterion 1.3.6.1	PA	RNs (interviewed) have access to specialist nursing wound care management advice as required. Staff have access to sufficient medical	Neurological observations had	Ensure neurological

<p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>Moderate</p>	<p>supplies, dressings and continence products. Resident files include continence assessments and plans as required.</p> <p>Electronic monitoring forms are completed and reviewed, for example, turning charts, food and fluid charts, blood pressure, weight charts and behaviour charts. Neurological observations had not been completed as per protocol.</p> <p>Twelve unwitnessed falls and corresponding progress notes were reviewed on the e-case system. Ten of the 12 neurological observations for unwitnessed falls had not been completed as per protocol.</p>	<p>not been completed for 10 of 12 unwitnessed falls as per protocol.</p>	<p>observations are completed as is required by protocol.</p> <p>60 days</p>
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.