# Radius Residential Care Limited - Radius Kensington

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Radius Residential Care Limited

**Premises audited:** Radius Kensington

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical

**Dates of audit:** Start date: 15 December 2014 End date: 16 December 2014

**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:** 60

# 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 |
|  | 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 Kensington is a Radius Group residential care facility located in Hamilton that provides care for up to 92 residents at hospital, rest home, residential disability and dementia level care. On the day of the audit there were 60 residents living at the facility, 22 were at the rest home level of care; 33 residents were at the hospital level of care, which included six residents under the age of sixty-five; and five residents were residing in the secure dementia unit.

There was one improvement identified during the last audit relating to residents accessing their call bells, which is now being met by the service. There were no improvements identified during this surveillance audit.

## 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. |

Residents and their families are kept informed of any adverse event or change in health status. Interpreter services are accessed when clients are unable to speak or understand English.

The complaints process is explained to residents and families as part of the admission process. Complaints information is also provided in writing. A complaints register is in place that includes all complaints, dates and actions taken. Twenty verbal and written complaints were received in 2014. All of these complaints have been documented as resolved.

## 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. |

A quality and risk management plan has been developed for the service which includes clinical and operational key performance indicators. The service has policies and procedures to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. Key components of the quality and risk management system include monitoring all adverse events. Data that is collected is analysed and the results are communicated to staff to facilitate improvements.

The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. There is an annual education schedule that is being implemented. In addition, opportunistic education is provided. Aged Care Education is in place for the healthcare assistants. Education and training for registered nurses and enrolled nurses is linked to external education provided by the Waikato District Health Board.

The facility is staffed appropriately with registered nursing cover 24 hours a day, seven days a week.

## 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. |

Service delivery plans demonstrate service integration. Nursing care plans reviewed were individualised, accurate and up to date. Care plans are goal oriented and are reviewed at least six monthly.

There is a comprehensive activities programme. The activities programme includes community contact. Activities in the dementia unit are appropriate and are often combined with the rest home entertainment. There are activities to meet the needs of the younger residents.

Medication management is managed well. Medications are reviewed by a general practitioner at least three monthly.

The menu is designed and reviewed by a registered dietitian at an organisational level. Residents have had a nutritional profile developed on admission. This is reviewed six monthly as part of the care plan review.

## 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. |

A current building warrant of fitness is in place.

Call bells are located in each of the residents’ rooms and are kept within reach of the residents. This is an improvement from the previous audit.

## 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. |

Restraint policies and procedures are in place and include the definitions of restraints and enablers. The service has 18 residents who have voluntarily requested an enabler in the form of bedrails or a lap belt to keep them safe. This is well documented in their files.

Staff receive education and training relating to the use of enablers and restraint.

## 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. |  | Standards applicable to this service fully attained. |

Infection control policies and procedures are in place. The monthly monitoring of infections is recorded. Collated data is discussed at the quality and staff meetings. The infection control co-ordinator uses the information to determine infection control activities, resources and education.

## Summary of attainment

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

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| **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 | 17 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 0 | 0 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints received is maintained by the manager using a complaints’ register. Documentation including follow up letters and resolution demonstrates that complaints are well-managed. Verbal complaints are also included and actions and responses are documented.  Discussions with six rest home and four hospital residents, and seven relatives confirmed they were provided with information on complaints and complaints forms. Twenty complaints (verbal and written) were received in 2014 (year-to-date) with evidence of appropriate and timely follow-up actions taken. All of the complaints received were resolved. One of the twenty complaints received was lodged with the Health and Disability Commissioner on 28 March 2014 and was signed off five months later with no action required. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any adverse event that occurs. Evidence of communication with family is recorded on the family communication record, which is held in the front of the residents’ files. Accident/incident forms indicate if next of kin have been informed (or not) of an accident/incident. Twenty incident forms that were reviewed across the rest home, hospital and secure dementia unit identified family are kept informed. All seven relatives interviewed stated that they are kept informed when their family member’s health status changes or following an adverse event.  An interpreter policy and contact details of available interpreters is in place. There is one resident who understands but is unable to speak English. Interpreter services are being used to assist with communication. The information pack is available in large print and is read to residents who require assistance.  Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. The residents and family are informed prior to entry of the scope of services and any items they have to pay that are not covered by the agreement. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Radius Kensington is a residential care facility, situated in Hamilton. The service currently provides care for up to 92 residents at hospital, rest home, residential disability and dementia level care. On the day of the audit there were 33 hospital residents including six residents under 65 years of age, 22 rest home residents and five residents in the secure dementia unit.  The Radius Group has an organisational philosophy, which includes a vision, mission statement and objectives. A site specific business plan for Radius Kensington links to the Radius Group Business Plan (2014 – 2017). The philosophy of the service includes providing safe and therapeutic care for residents. And for those residents with dementia, providing services that enhance their quality of life and minimises risks associated with their confused states. Clinical and operational key performance indicators have been determined, which includes predetermined targets.  The manager is a registered nurse with many years’ experience in aged care management and has been at Kensington for just over one year. She is supported by a clinical nurse leader who also is a registered nurse with previous aged care experience and the Radius regional manager who oversees six Radius facilities including three with dementia units.  The manager has maintained over eight hours annually of professional development activities relating to the management of an aged care facility, which includes attendance at Radius manager conferences. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management system is being maintained. Quality and risk performance is reported across the facility meetings, staff notice board and also to the organisation's senior management team.  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. A system for document control is in place. Any new policies or changes to policy are communicated to staff, evidenced in staff meeting minutes and in interviews with all eleven staff (four healthcare assistants, four nurses, one cook and two activities staff).  Key components of the quality management system include monitoring medication errors, restraint use, weight loss, pressure areas, infections, wounds and resident satisfaction. Weekly reports by the manager to the regional manager provide a coordinated process between service level and the organisation. There are monthly accident/incident reports completed that break down the data collected across the rest home, dementia unit, and hospital units and staff incidents/accidents. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds, assessment and exercises by the physiotherapist, landing strips by beds and sensor mats  An internal audit programme is in place that monitors key components of the service. Quality and risk data that is collected is collated, evaluated and the results are communicated to staff to facilitate improvements. If an area of noncompliance is identified, there is evidence of a corrective action plan. Quality initiatives over the past year have included the implementation of a fitness programme for the residents that was designed by a physiotherapist, and implementing strategies to assist residents who are sun downing (restless at night) and residents who experience difficulty with breathing.  A comprehensive health and safety programme in place. The organisation has achieved tertiary certification through the ACC Workplace Safety Management Practices. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. Data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Minutes of the monthly staff meetings reflect a discussion of results. Twenty incident forms were reviewed. The events reflected a clinical assessment and follow up by a registered nurse.  Discussions with the management team (regional manager, manager, and clinical nurse leader) confirm their awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files that were reviewed (two healthcare assistants, one enrolled nurse (EN), one RN and the clinical nurse leader) included evidence of the recruitment process, employment contract, orientation, and annual performance appraisals.  The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type (e.g. RN, support staff). Staff interviewed stated that they believed new staff were adequately orientated to the service.  A register of RN and EN practising certificates is maintained.  There is an annual education schedule that is being implemented and covers more than eight hours annually. In addition, opportunistic education is provided. Aged Care Education (ACE) is provided for the healthcare assistants. Education and training for RNs and ENs is linked to external education provided by the Waikato District Health Board. Discussions with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place.  The dementia unit has been open for less than six months. There are seven healthcare assistants and three activities staff that work in the dementia unit. Four healthcare assistants and two activities staff have completed the required dementia standard, and the remaining staff are enrolled in the programme and are in the process of completing theirs with completion dates targeted to occur prior to the six month timeframe. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes.  The manager and clinical nurse leader are RNs and work full time Monday – Friday.  Two nurses cover the day shift (one RN and one RN or EN) and evening shift (one RN and one RN or EN) with one RN covering the night shift, seven days a week. Healthcare assistants are adequately staffed to meet the needs of the residents. One healthcare assistant staff is rostered on each shift to cover the dementia unit, caring for five residents. Interviews with four healthcare assistants and four nurses confirmed that staffing levels are sufficient to meet the needs of the residents. Interviews with the residents and relatives confirmed staffing overall was satisfactory. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are comprehensive medication policies in place. All medication is managed appropriately in line with required guidelines and legislation. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival.  All staff administering medication have completed an annual medication competency. There are no residents who self-administer medicines. Twelve medication charts were reviewed. They were all were clear and easy to understand. Signing on administration was up to date including as required (PRN) medication. All ‘as required’ (PRN) medication had indication for use included on the medication chart. Resident photos and allergies are on all the drug charts.  Twelve medication charts reviewed identified that the GP had reviewed each resident three monthly, or more, and the medication chart was signed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The service has a large, workable and well-equipped kitchen. The menu is designed and reviewed by a registered dietitian at an organisational level. There are winter and summer menus, which follows a four week rotational diary.  All meals are cooked in the main kitchen and served from the kitchen directly to the residents in the main dining room, dementia care dining room and the hospital dining room.  Diets are modified as required. There is an alternative available. On the day of audit meal times were well staffed with all staff assisting with meal services.  The cook was able describe the meal requirements of the residents.  Kitchen fridge, food and freezer temperatures are monitored and documented by the cook.  All residents have a nutritional profile completed on admission and copied to the kitchen. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen by the registered nurses.  In the dementia unit, additional snacks were available to residents 24 hours per day. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Five resident files were reviewed. The care plans were well documented.  All ten residents interviewed reported their needs were being appropriately met.  The long term care plans reviewed were supported by assessments and identify the level of intervention to meet the identified needs, and goals/objectives.  Dressing supplies are available and a treatment room is stocked for use.  Continence products are available and resident files include an up-to-date urinary continence assessment and bowel management. Continence products were identified for day use, night use, and other management.  Wound assessment and wound management plans/skin tear plans are in place for thirteen wounds including three pressure areas. The wound care plans are comprehensive and documented well.  An interview with the visiting nurse practitioner evidences that she is happy with the service and care provided. |
| Standard 1.3.7: Planned Activities  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. | FA | Radius Kensington have a diversional therapist and two activity assistants who provide cover seven days a week. The service continues to provide a high standard of activities for the rest home, hospital, dementia care and younger residents with a disability. At the time of audit there were interactive activities provided in the rest home, hospital and dementia unit. All were well attended by the residents including those under 65 years old who report enjoying activities and having input into the activities programme. The service combines the three units for visiting entertainment.  Activities are completed in each of the lounges in the rest home, the hospital and dementia unit. There is an activities section in the resident file that includes activities assessment, life experiences' and personal history profiles.  Ten residents interviewed stated the activities programme is enjoyable and interesting. Van outings are provided regularly each week.  All five residents’ files reviewed identified that the individual activity plan is reviewed six monthly or more as required. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The evaluation and care plan review policy require that care plans are reviewed six monthly, or as the residents’ condition changes. The evaluations form describes progress against set goals and needs identified in the care plan (sighted). Short term care plans are well utilised. Any changes to the long term care plan, including six monthly reviews, are dated and signed by the registered nurse.  Short term care plans were cited for wounds, weight loss, urinary tract infections, hydration and poor appetite.  All initial care plans were evaluated by a registered nurse within three weeks of admission. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed in a visible location (expiry date 13 July 2015). |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The previous audit identified that residents could not always reach their call bells. Call bells are installed in each of the residents’ rooms. During the audit, call bells were observed to be in close proximity to the residents. Interviews with all ten residents confirm that call bells are kept within their reach. Call bell audits are regularly conducted with no concerns reported in the audit results. Reminders to staff to ensure that residents always have access to their call bell are documented in staff meeting minutes. These are improvements from the previous audit. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Radius Kensington has infection control policies and procedures in place. There is monthly monitoring of infections recorded in the infection control folder. The collated data is discussed at the quality and staff meetings. The infection control co-ordinator, who is also the clinical nurse leader, uses the information to determine infection control activities, resources and education. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the healthcare assistants and nursing staff confirm their understanding of restraints and enablers.  The service has three residents with bedrails on the restraint register (hospital level) and eighteen residents with enablers in the form of bedrails and one lap belt. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. The use of enablers is linked to the residents’ care plans. |

# 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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| No data to display |

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

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

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

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

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End of the report.