

Radius Residential Care Limited - Radius Kensington

Introduction

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

The audit has been conducted by 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 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: 29 July 2015 End date: 30 July 2015

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: 80

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

General overview of the audit

Radius Kensington is owned and operated by Radius Residential Care Limited and can provide care for up to 92 residents requiring rest home, dementia, hospital and residential disability (physical) level care. On the day of the audit there were 80 residents. The manager is well qualified and experienced for the role and is supported by a clinical nurse manager and the Radius regional manager.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

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

This audit has identified areas for improvement around informing families of incidents, investigation of incidents and wound documentation.

The service has exceeded the required standard around business goal planning and review, leadership training for the management team and provision of activities.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Staff at Radius Kensington strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

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.		Some standards applicable to this service partially attained and of low risk.
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The facility manager is qualified and experienced for the role and she is supported by an organisational team, a clinical nurse manager, registered nurses and care staff. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities, including Radius key performance indicators are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings 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. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

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 low risk.</p>
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The service has a well-developed assessment process and resident's needs are assessed prior to entry. Assessments, care plans and evaluations are completed by the registered nurses. Residents/relatives are involved in planning and evaluating care. Risk assessment tools and monitoring forms are available 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 service facilitates access to other medical and non-medical services.

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

Meals are prepared on site. Individual and special dietary needs are catered for. Residents interviewed responded favourably about 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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Radius Kensington has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by an authorised technician. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. There is a designated laundry and cleaner's room. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

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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Radius Kensington 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 residents with restraint and 17 residents with an enabler. Restraint management processes are adhered to.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained Standards applicable to this service 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	46	0	3	0	0	0
Criteria	2	96	0	3	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (six healthcare assistants (HCA's) – one from the dementia unit and five from the rest home/hospital, three registered nurses, the administrator, three activities coordinators, the facility manager and the clinical nurse manager) confirm their familiarity with the Code. Interviews with 11 residents (six from the rest home including one under 65 years old and five from the hospital including two under 65 years old) and 10 relatives (three rest home, five hospital and two from the dementia unit) confirm the services being provided are in line with the Code. Code of rights and advocacy training has been provided.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed</p>	FA	<p>Resident admission agreements were signed in the files sampled. Informed consent processes are discussed with residents and families on admission. Written consents were signed by the resident or their EPOA in files sampled. Advanced directives are signed for separately.</p>

<p>choices and give informed consent.</p>		<p>There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Health care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>Resident files sampled (four from the hospital, three from the rest home and two from the dementia unit) have signed admission agreements and consents.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Interviews with residents and relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans. Discussions with residents and relatives verify that they are supported and encouraged to remain involved in the community. Staff at Kensington support on-going access to community. Entertainers are invited to perform at the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>A complaints policy and procedure is 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</p>

		<p>appropriate actions have been taken in the management and processing of complaints. One complaint is being investigated by the Health and Disability Commissioner. A complaints procedure is provided to residents within the information pack at entry.</p> <p>There is written information on the service philosophy and practices particular to the dementia unit included in the information pack.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information is provided to residents and family members of Radius Kensington that includes the Code, complaints and advocacy information. Residents and relatives confirmed this on interview. The facility manager and clinical nurse manager provide an open-door policy for concerns or complaints. Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. Resident meetings have been held providing the opportunity to raise concerns in a group setting.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Church services are held fortnightly. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirm the service is respectful and that they are given the right to make choices. Care plans reviewed identified specific individual likes and dislikes. Staff education and training on abuse and neglect has been provided.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There is a Radius Māori health plan and an individual's values and beliefs policy, which includes cultural safety and awareness. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. Residents who identify as Māori have this included in their care plan. There is information and</p>

		links to websites provided within the Māori health plan to provide quick reference and links with local Māori. Interviews with staff confirm they are aware of the need to respond appropriately to maintain cultural safety. Cultural safety training has been provided.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	Residents interviewed indicated that they were asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed. Family involvement is encouraged e.g. family are invited to residents meetings and facility functions. Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	The staff employment process includes the signing of a code of conduct and there has been recent staff training around this. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with staff and management. Interviews with staff confirm their understanding of professional boundaries.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	The Radius quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Policies and procedures have been reviewed; and updated at organisational level and are available to staff. Quality/staff meetings and residents meetings have been conducted. Residents and relatives interviewed spoke very positively about the care and support provided. Staff had a sound understanding of principles of aged care and state that they feel supported by the facility manager and clinical nurse manager. There are implemented competencies for health care assistants and registered nurse. There are clear ethical and professional standards and

		boundaries within job descriptions.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>Residents interviewed 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 did not consistently evidence recording of family notification. Relatives interviewed confirmed they are notified of any changes in their family member's health status. The facility manager and registered nurses were able to identify the processes that are in place to support family being kept informed.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for, that are not covered by the agreement.</p> <p>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>	CI	<p>Radius Kensington is part of the Radius Residential Care group. The service currently provides rest home, hospital and dementia level care and residential disability (physical) for up to 92 residents. On the day of the audit there were 80 residents - 29 rest home, 38 hospital and 13 dementia level residents. This includes six residents on younger persons with disability contracts, six on short term respite care, two residents on long term chronic conditions contracts and three funded by ACC who are under 65 years old.</p> <p>The facility manager is well trained and experienced and has been in the role for two years. She is supported by a competent clinical nurse manager and the Radius regional manager. Radius has an overall business/strategic plan and Radius Kensington has a facility quality and risk management programme in place for the current year. The business plan includes business goals. Progress toward goals is regularly reported. The organisation has a philosophy of care, which</p>

		<p>includes a mission statement. The facility manager has completed in excess of eight hours of professional development in the past 12 months.</p> <p>The service has exceeded the standard around the identification of the scope, direction and goals of the service and regular review of these goals and the training of the manager and benefits of this to the staff, residents and families.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the facility manager, the clinical nurse manager is in charge with support from the regional manager, the registered nurses, the administrator and care staff.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is an organisational business plan that includes quality goals and risk management plans for Radius Kensington. There is evidence that the quality system continues to be implemented at Radius Kensington. Interviews with staff confirmed that quality data is discussed at monthly quality meetings, which are open to all staff. The facility manager advised that she is responsible for providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed at national level by the clinical managers group, 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 regional manager and monthly data is collated in relation to Radius key performance indicators (KPI).</p> <p>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 and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. There is a death/Tangihanga policy and procedure that outlines immediate</p>

		<p>action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>There is an accident and incident reporting policy. Accidents and near misses are investigated by the clinical nurse manager and analysis of incident trends occurs. Incidents are included in the Radius KPI's. There is a discussion of incidents/accidents at monthly staff meetings including actions to minimise recurrence. Clinical follow up of residents is conducted by a registered nurse as confirmed in 15 incident reports sampled. However, not all have been investigated to explore opportunities to minimise the risk of recurrence. 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.</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, which includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Nine staff files were reviewed and 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 orientation programme is relevant to the dementia unit and includes a session on how to implement activities and therapies. The in-service education programme for 2014 has been completed and a plan for 2015 is being implemented. Healthcare assistants have completed an aged care education programme. The clinical nurse manager and 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. Six monthly fire evacuation drills have been conducted.</p>

		There are 10 caregivers who work in the dementia unit. Six have completed the ACE dementia NZQA standards and the other four are all enrolled and have not yet worked in the dementia unit for 12 months. The activities coordinator in the dementia unit has completed dementia unit standards.
<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	Radius policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The clinical nurse manager works full time and the facility manager is a registered nurse. Additionally there are three registered nurses on each morning duty, two on afternoon duty and one on night duty. The facility manager and staff interviewed, 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>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record (link 1.2.1.3). Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible and signed by the relevant healthcare assistant or registered nurse but do not consistently document the time of entry. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for</p>	FA	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical nurse manager screens all potential residents prior to entry and records

<p>services has been identified.</p>		<p>all admission enquiries. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the clinical nurse manager. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are policies to describe guidelines for death, discharge, transfer, documentation and follow up. Records are kept with the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.</p>
<p>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.</p>	<p>FA</p>	<p>The service uses individualised robotic packs. Medication charts have photo identification. Robotic pack medications are checked on arrival by the RN 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 cupboard or in the fridge.</p> <p>RN's or senior caregivers administer the medication. Annual medication competencies are completed. The registered nurse advised there were no residents self-medicating on the day of audit.</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>Three registered nurses were observed administering medications correctly. Resident photos and documented allergies, or nil known, were noted on the sample of 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 Kensington are prepared and cooked on site. There is a four weekly winter and summer menu, which had been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen adjacent to the dining room and served directly to residents. Hospital and dementia level residents are provided with meals using hot boxes. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. Staff were observed assisting residents with their lunch time meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the registered nurse or clinical nurse 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 dietician. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining entry to the service would be recorded on the declined entry form, and when this has occurred, the service stated it had communicated to the resident/family and the appropriate referrer.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission, which formed the basis of resident goals and objectives. Assessments are reviewed at least six monthly. Appropriate risk assessments had been completed for individual resident issues in all files sampled. Three registered nurses and the clinical nurse manager (RN) have completed InterRAI training.</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>Resident files sampled included all required documentation. The long-term care plan recorded the resident's problem/need, objectives, interventions and evaluation for identified issues in files sampled. The service has a specific acute health needs care plan that included short-term cares. Resident files reviewed identified that family were involved in the care plan development and on-going care needs of the resident.</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 Low</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. Dressing supplies were available and a treatment room was stocked for use. Continence 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. Wound assessment and wound management plans were in place for seven residents including one pressure area that was not acquired at the facility. Documentation around reviews of wounds was not completed for all wound care plans reviewed.</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 two activity co-ordinators who provide activities in the rest home and hospital and an activities co-ordinator who organises activities in the dementia unit across seven days. All three activity co-ordinators have completed the ACE dementia standards and one is currently completing level four diversional therapist units. The activities programme is able to cater for the needs of all levels of care provided at Radius Kensington.</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. Consideration is giving to providing appropriate activities for younger people. Residents have an activities/social profile assessment completed over the first few weeks</p>

		<p>after admission obtaining a complete history of past and present interests, career, family etc.</p> <p>The programme observed in the dementia unit was appropriate for people with cognition and memory impairments. Activities are age appropriate and are planned. There are several programmes running that are meaningful and reflect ordinary patterns of life. There are also visits from community groups.</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>The service has exceeded the required standard around providing activities to meet resident's needs.</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, or when changes to care occurred, by the 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 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Discussions with the clinical nurse manager and the registered nurse (RN) identified that the service has access to external and specialist providers. Referral documentation was maintained on resident files sampled.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from</p>	FA	<p>The waste management policy and procedure outlines processes. Staff were observed wearing appropriate protective clothing. All chemicals sighted were appropriately stored in locked areas and fully labelled. There is an incident reporting system that is in use. A comprehensive</p>

harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		emergency plan is available to staff in both nurses' stations, which includes hazardous substances.
<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 service displays a current building warrant of fitness, which expires on 13 July 2016. Hot water temperatures are checked weekly. Medical equipment and electrical appliances have been tested, tagged, and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior areas are well maintained with safe paving, outdoor shaded seating and gardens. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</p> <p>The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required.</p> <p>The secure dementia area has a separate lounge and dining area, they were both well supervised on the day of audit. There is a secure outside/courtyard area.</p> <p>The external areas are well maintained and all residents' wings have access to courtyard gardens and indoor areas with ease.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All resident rooms in Radius Kensington are single rooms. There are hospital/rest home resident rooms, which have ensuite. There are a number of hospital/rest home residents' that share communal bathrooms and toilets. There were sufficient numbers of resident communal bathrooms and toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed state their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets and showers were well signed and identifiable and include large vacant/in-use signs. The dementia unit has adequate number of communal toilets and showers close to residents' rooms.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The resident rooms are spacious enough to meet the assessed resident needs. Residents were able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Healthcare assistants interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms are personalised.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are lounge areas and a separate dining room, and small seating areas by the reception. The dementia care level unit has a lounge/dining area. The main dining room was spacious, and located directly off the kitchen/server area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed report they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is done on site in the commercial laundry, by dedicated laundry staff. Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of</p>

		<p>orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is rostered on and available at all times.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All communal and resident bedrooms have external windows with plenty of natural light. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Radius Kensington has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPI's. The clinical nurse manager is the designated infection control nurse with support from the facility manager, the registered nurses and all staff (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Radius infection control programme was last reviewed in July 2014.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The clinical manager at Radius Kensington is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff through the staff/quality meeting) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection</p>

		control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	There are Radius infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection control policy states that the facility is committed to the on-going education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	Infection surveillance is an integral part of the infection control programme and is described in Radius's 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 on to a monthly infection summary. This data is monitored and evaluated monthly and annually, and 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 facility manager. There

		have been no outbreaks reported.
<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 minimized. There were four hospital residents with restraint and 17 residents with an enabler. 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. Enabler use is voluntary. Staff education on RMSP/enablers has been provided. Restraint use audit has been conducted and restraint has been discussed as part of staff/quality management meetings. The clinical nurse manager is the designated restraint coordinator.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The clinical nurse manager is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner as evidenced in the sample of files reviewed.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whānau in the two files sampled for residents with restraint and the three files sampled for residents with enablers. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the restraint and enabler files reviewed, assessments and consents were fully completed. Consent for the use of restraint was completed with family/whānau involvement and a specific consent for enabler/restraint form was used to document approval.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the files reviewed, however, documentation gaps were noted. Files reviewed had a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. In resident files reviewed, appropriate documentation has been completed. The service had a restraint and enablers register, which was up dated each month.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service has documented evaluation of restraint every three months. In the restraint and enabler files reviewed, evaluations had been completed with the resident, family/whānau, restraint co-ordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the facility restraint co-ordinator at quality/staff meetings. Evaluation timeframes are determined by policy and risk levels. The evaluations sighted had been completed with the resident, family/whānau, restraint co-ordinator and medical practitioner.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint co-ordinator. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported at the monthly meetings. Restraint and enabler use is discussed in monthly quality/staff meetings.</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 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	Ten families interviewed report they feel they are informed when there is a change in resident's condition or an incident occurs. Ten of 15 incident forms sampled documented that the family member had been informed of the incident.	Five of 15 incident forms reviewed did not have documented evidence in the family contact record, or progress notes, or on the incident form that family were informed.	<p>Ensure family are informed of all incidents.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	Incident forms are completed by the person initially involved in the incident and then passed to the registered nurse for clinical follow up. There is evidence on all 15 incident forms sampled that follow up by a registered nurse has occurred. Six of the 15 incident forms document investigation and identification of opportunities to reduce the risk of recurrence. The clinical nurse manager reports that she sights all forms and	Nine of 15 incident forms sampled have not had a documented analysis in order to identify opportunities to improve service delivery and to identify and manage risk.	<p>Ensure all incidents have a documented analysis in order to identify opportunities to improve service delivery and to identify and manage risk.</p> <p>90 days</p>

		where she feels an investigation is warranted or there may be an opportunity to reduce the risk of recurrence, she documents this, otherwise she simply signs it off. Therefore the risk is low. All 15 incident forms have been signed off by the clinical nurse manager.		
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	There are policies and procedures outlining the requirements around documentation of assessment, management, evaluation and reviews of resident wounds. Eight wounds documentation were reviewed.	<p>i) Three of eight wounds do not have documented evidence of review in stated timeframes. Staff report the wounds have been reviewed and this is a documentation error; ii) Two wounds for one resident have a combined assessment and management plan.</p>	<p>i) Ensure that the review of wound documentation is completed within the stated timeframes; ii) Ensure that each wound has its own assessment, evaluation/review and management plan.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>There is an organisational business plan and Radius Kensington has an April 2015 to May 2016 business plan with a series of measurable goals for the service that flow from the goals in the organisational plan.</p>	<p>The facility manager provides a documented monthly report to the Radius regional manager. The regional manager visits regularly and completes a report to the general manager Care Homes. The managers in the region meet monthly and a forum is held annually with all the Radius managers. Quarterly quality reports on progress towards meeting the quality goals identified are completed at Radius Kensington, and forwarded to the regional manager. Meeting minutes reviewed included discussing on-going progress to meeting their goals. Radius Kensington's annual goals link to the organisations goals and this is also reviewed in quality meetings. This provides evidence that the quality goals are a 'living document'. Goals from the 2014 and 2015 business plan have either been met or carried forward. Examples of goals met for the previous year include surveillance audits being met with no partial achievements; the opening of the dementia unit in</p>

			<p>December 2014; and reducing the incidence of skin trauma. The reduction of incidents of skin trauma included staff training in safe manual handling. Attendance records for these education sessions were as follows: 69.8% of staff attending in April 2014, 87.5% attending in October 2014 and 90% attending in February 2015. Additionally, a rounding log was initiated whereby staff document sighting 'at risk' residents at regular intervals. The goals for the New Year were set in April 2015 and are grouped around clinical effectiveness, consumer participation, human resources, risk management, revenue, property and being respected leaders in the field. Achievement for the first quarter against the goals has been documented and includes the manager, clinical nurse manager and administrator attending the first leg of customer service training, no staff accidents in the quarter, no serious complaints (the report details the complaints which have been received) and the progress of the falls reduction project.</p>
<p>Criterion 1.2.1.3</p> <p>The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.</p>	CI	<p>The manager at Radius Kensington is a registered nurse who has worked in aged care management for many years and has been in the current role for two years. She is supported by a triangle of support (the clinical nurse manager and administrator) and the Radius regional manager.</p>	<p>In 2014, the Radius business plan included a goal around the development of facility managers as leaders – for leaders to find the best in themselves. To innovate, develop their site and focus on their team to inspire positive behaviours that filter through the organisation. The Radius managers' conference included leadership development around emotional intelligence, self-awareness, empathy, competence, personal influence and reflective practice, personality preferences and resonant and dissonant styles of leadership. Following this, the Radius Kensington manager completed self-directed learning using Boyatzis' approach to self-directed learning. As a result of these sessions the manager has identified her strengths and weaknesses, and through support and encouragement and mentoring from the regional manager, gained confidence in having crucial conversations. On interview, the manager advised that</p>

			<p>she has developed an understanding that leadership is about relationships, is everyone's business and is self-development. The manager has identified the management relationships of her senior team.</p> <p>Throughout 2014 and 2015 the Radius Waikato/Bay of Plenty regional managers have continued leadership training and this has resulted in further development for the Radius Kensington manager. This has included training around skills of communication in interpersonal styles, skills of dynamic leadership, the five dysfunctions of a team, understanding cultures in the work place and skills through the eight steps of successful change. The outcomes have been that the manager has created a sense of urgency to achieve goals (including opening of dementia level beds). There has been a pulling together of the guiding team, with improved communication for understanding and buy in (this was reported by staff interviewed).</p> <p>The training in leadership of the triangle of support led to the administrator (part of the triangle of support) to develop goals around to improving departmental document control. This has occurred through leading and educating the team, taking control of the facility documentation as occupancy increased, improving efficiency and encouraging best practice throughout the group. There have been a number of positive results from this cascading leadership. In the first six months of 2015, Radius Kensington have had 93 admissions. Admission files are prepared in advance by the administrator for clinical staff prior to admission, to ensure they are ready to receive the new resident.</p> <p>The administrator also ensures admission agreements are signed on day of admission. This facility has 100% record of these being loaded and all admission documentation has been completed within contractual timeframes.</p>
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End of the report.