

Radius Residential Care Limited - Radius Arran Court Home & Hospital

Introduction

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

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

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

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

The specifics of this audit included:

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| Legal entity: | Radius Residential Care Limited |
| Premises audited: | Radius Arran Court Rest Home & Hospital |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 27 August 2015 End date: 27 August 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: | 90 |



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Arran Court provides rest home and hospital level care for up to 102 residents. The service is managed by the facility manager, with support from a clinical manager. Residents and relatives interviewed during the audit spoke positively about the care and support provided by staff.

This unannounced audit was conducted against a sub-set of the relevant Health and Disability Standards and the agreement with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed all four shortfalls from the previous certification audit, which related to quality data analysis, care planning, wound management and aspects of medicines management. This audit identified that an improvement is required to the timeliness of InterRAI LTCF assessments following admission.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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The service practices open disclosure and the facility manager and clinical manager operate an open door policy. Families are informed of changes in resident's health status or incidents in a timely manner. The right of the consumer to make a complaint is understood, respected, and upheld. Complaints processes are implemented and complaints and concerns are managed and documented.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |
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Governance is provided by the Radius Care managing director. The director, corporate general manager and corporate team ensure services are planned, coordinated, and appropriate to the needs of the residents. There is an established, documented, and maintained quality and risk management system in place that reflects continuous quality improvement principles. The service has a range of policies and procedures that are aligned with current good practice and service delivery, which are regularly reviewed. Incidents and accidents are managed according to policy. Quality improvement data is collected, analysed, and evaluated and the results communicated to service providers and residents. Corrective action plans are utilised to make quality improvements within the service. Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services.

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. | | Some standards applicable to this service partially attained and of low risk. |
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Resident's needs are assessed prior to entry and immediately thereafter. Assessments, care plans and evaluations are completed by the registered nurses. Residents and 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 used for changes in the health status of residents. 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 medicines management system follows recognised standards and guidelines for safe medicine management practice. Staff complete competencies prior to administering medicines. Meals are prepared on site. Individual and special dietary needs are met. Residents interviewed responded favourably about the food that was provided.

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Standards applicable to this service fully attained. |
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The facility has a current building warrant of fitness. There have been no changes to the building since the previous certification 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. |
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Restraint minimisation is practiced. The service has alternative systems available so that staff can use restraint as a last resort strategy. On the day of audit, there were four residents with restraints and nine residents with enablers. The service has alternative systems available so that staff can use restraint as a last resort strategy. Enablers are voluntary.

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. |
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The infection prevention and control programme includes the surveillance programme, which is managed by the clinical manager with assistance from an enrolled nurse and other registered nurses. There are established systems in place, which are appropriate to the needs of residents and visitors to the premises. There has been one small outbreak of norovirus since the previous audit, which was effectively managed and resolved within days.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 0 | 16 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 0 | 39 | 0 | 1 | 0 | 0 | 0 |

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

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>Staff, residents and families interviewed were aware that residents, and where applicable, their representatives, have the right to make a consumer complaint. There is an established consumer complaints management system in place, which includes a feedback system. All consumer complaints are listed in an electronic and a paper-based complaints register. Of the 12 complaints received since the previous audit, nine were determined to be justified following investigation, and appropriate actions were taken where applicable. One of the 12 consumer complaints remains open. The complaint concerns an incident, which occurred between two residents. The incident was notified to the Police, the DHB and to HealthCERT. The matter is being investigated by the Police. No staff were involved in the incident.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>The service has policies and procedures in place to ensure that residents and their relatives are communicated with effectively. Staff practice open disclosure (confirmed in discussions with the facility manager, the clinical manager and in review of documentation). Records are kept of discussions with families. Interpreter services are available if needed. Open communication was also confirmed in interviews with seven residents (five hospital and two rest home) and</p> |

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| | | two hospital relatives. |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>Arran Court is part of the Radius Residential Care Group. The service is certified to provide hospital – geriatric and medical, and rest home care for up to 102 residents. On the day of audit, there were 37 rest home residents, 53 hospital residents. Three of these residents were on under 65 year old contracts (one rest home and two hospital). There were no respite residents and no residents on a medical contract. All beds are certified as dual purpose beds.</p> <p>Governance of the business is provided by the managing director. The director and the corporate team actively manage the business to ensure that services are provided in accordance with expectations as articulated in the business plan. The plan documents the mission, philosophy and objectives. The managing director reviews the plan every year in consultation with the operational management team. The facility manager has input into this process.</p> <p>The director employs a facility manager who has been in the position since May 2014. She is a registered nurse with a current practising certificate and holds a post graduate diploma in education. The facility manager is supported by an experienced clinical manager, who has been in the role since May 2015.</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>The facility has a quality plan, which is included in business plan that is reviewed yearly to measure achievement. The service has in place a range of policies and procedures to support service delivery that are reviewed at least bi-annually if not earlier. The policies include reference to the InterRAI Long Term Care Facilities Assessment System (InterRAI LTCF). Key components of service delivery are linked to the quality and risk management system including resident satisfaction, health and safety, the management of adverse events, restraint minimisation, and infection prevention and control. The previous audit finding relating to analysis of quality data has now been addressed. All quality improvement data is being recorded by the facility manager and reported monthly to the operations management team, through the regional operations manager. Data is evaluated and results used for quality improvement. There are a number of quality meetings held, including a monthly continuous quality improvement (CQI) meeting, monthly staff meetings, monthly management meetings, monthly registered nurse (RN) meetings and monthly resident meetings. Information on quality and risk management is conveyed to staff through handover sessions and the monthly staff meetings. Corrective actions are documented. Actual and potential risks are identified, documented and where appropriate communicated</p> |

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| | | to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. The service maintains a site specific risk register and a facility specific hazard register. Risks are identified, monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk. Risks are actively managed. |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | FA | <p>There is an accident/incident reporting and an open disclosure policy/procedure that includes definitions. When an incident occurs, the healthcare assistant (or staff discovering the incident) complete a form and the RN will undertake an initial assessment. The RN will notify family and the GP as required. The clinical manager collects incident reports daily and reviews both the incident and actions taken. Where the action taken is not considered to have been comprehensive, the clinical nurse manger will investigate and escalate to the facility manager. Twenty-three accident/incident forms sampled for the month of July 2015 evidenced detailed investigations and corrective action plans following events. Data is reported to head office for internal benchmarking. Monthly data is taken to the twice-weekly management meeting. Staff interviewed could describe the process for management and reporting of incidents and accidents. Management are aware of the need to notify relevant authorities in relation to essential notifications (link 1.1.13).</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>Human resources policies are implemented to meet the requirements of legislation. Prospective employees undergo reference checking, checks for criminal convictions, and qualification checks (confirmed in review of six employee records, which included the clinical nurse manager, four health care assistants and the senior cook). New employees complete an orientation programme. The service employs 14 RNs (of whom one is the facility manager and one is the clinical manager). The facility manager, the clinical manager, and two RNs are InterRAI competent and two other RNs are in training, which enables the service to meet its InterRAI obligations. An annual in-service education programme is in place and a record of education attendance and achievement maintained. Health care assistants (HCAs) are encouraged and supported to complete ACE training. The clinical manager is an approved assessor with the New Zealand Qualifications Authority (NZQA) and her job description includes responsibility for in-service education. The service has seven HCAs who have level three NZQA qualifications or equivalent and 20 HCAs in training. RNs are supported to meet their professional development obligations including InterRAI</p> |

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| | | training. |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>The service has a documented rationale for determining staffing levels and skill mix for safe service delivery specified in the acuity and clinical staffing ratio policy. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and the clinical manager work 40 hours per week, with support from the corporate team.</p> <p>The clinical manager and the facility manager share on call duties around clinical matters. HCAs are not involved in providing other support services (eg, laundry). Staff turnover has been stable. The service occasionally uses agency staff. Staff, residents and family interviewed advised there is sufficient staff rostered on to meet the needs of the residents.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | FA | <p>The service uses two weekly robotic packs. Twelve of 12 medication charts reviewed (four rest home and eight hospital) have photo identification. The robotic pack medications are checked on arrival by the registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are stored securely. Checks of controlled drugs occurred weekly. Staff sign for the administration of medications on medication sheets held with the medicines. There were no expired medications in the medication cupboards or fridges. All medications were charted correctly. The previous audit findings have now been addressed and monitored.</p> <p>RNs or senior health care assistants administer the medication in both areas. Annual medication competencies are completed. Allergies are identified on the medication record. The registered nurse advised there were no residents self-medicating on the day of audit. The medication folder includes a list of specimen signatures.</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). Medication charts reviewed, identified that the GP had seen and reviewed the resident at least three monthly.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional</p> | FA | <p>There is a large workable kitchen with two cooks. Both have completed food safety training. All residents have a nutritional and hydration care requirement developed on admission, which is reviewed at the six monthly review. Copies were in a folder in the kitchen. Any special dietary requirements and food</p> |

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| <p>needs are met where this service is a component of service delivery.</p> | | <p>preferences are communicated to the kitchen and individual meals are supplied. The menu is designed and reviewed by a registered dietitian. Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented. Food temperatures are checked and documented prior to serving. Equipment is available on an 'as needed' requirement. Residents requiring extra assistance to eat and drink are helped by health care assistants and were observed during lunch.</p> |
| <p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>FA</p> | <p>Six of six care plans sampled document interventions for all assessed needs and support. Files reviewed demonstrated that care plans were individualised and demonstrated service integration and input from allied health. There was evidence of short-term care plans in use for changes in health status. The previous certification audit finding has been addressed.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>The care being provided is consistent with the needs of residents.</p> <p>Residents' needs are assessed prior to admission. The service has a house GP that visits weekly or as required. During the tour of facility, it was noted that all staff treated residents with respect and dignity.</p> <p>Dressing supplies are available and a treatment room/cupboard is stocked for use in each unit. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.</p> <p>Eighteen of 18 wounds reviewed had wound assessments and wound management plans in place. The plans include the timeframe for review of the wounds. Eighteen of 18 wounds had been reviewed in the stated timeframe. The previous audit finding has now been addressed.</p> <p>There were three pressure wounds in the facility on the day of the audit, which had been acquired before admission to Arran Court. The registered nurse interviewed described the referral process should they require assistance from a wound specialist.</p> |
| <p>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.</p> | <p>FA</p> | <p>Three activities coordinators provide activities in the rest home and the two hospital units across the week. The activities programme is able to cater for the needs of hospital level residents.</p> <p>On the day of audit, residents were observed being actively involved with a variety of activities in the rest home and the hospital units. The programme is</p> |

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| | | <p>developed weekly and all residents are given a copy, which details all activities occurring in the facility. Residents are encouraged to attend activities in different areas as they wish. Residents have an activities/social profile assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, and family.</p> <p>Activities are age appropriate and planned. The programmes include but not limited to, one on one time, current affairs, quizzes and exercises. There are also visits from community groups, external speakers and entertainers. There are fortnightly church services and weekly catholic mass.</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 at the care plan review.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>In the files sampled, care plans were evaluated by the registered nurse six monthly or when changes to care occur. Evaluations are documented and include progress to meeting goals. There was documented evidence of care plans being updated as required.</p> <p>There is at least a three monthly review by the GP.</p> <p>There were short-term care plans in place to focus on acute and short-term issues in the sample of files reviewed.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | <p>There is a current building warrant of fitness which expires on 8 December 2015. There have been no changes to the building since the last certification audit.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>The clinical manager is the infection prevention and control (IPC) coordinator. An enrolled nurse and the registered nurses assist her. The facility manager supports the IPC coordinator. The surveillance programme is outlined in the IPC programme and in policy. Infection monitoring is the responsibility of the IPC coordinator. The coordinator, with the assistance of the enrolled nurse, records actual and suspected infections in the infection register and generate a monthly analysis of the data that is reported to head office. The analysis is also reported to the monthly CQI meetings, the monthly RN meetings and the monthly main staff meetings. There is evidence of general practitioner involvement and</p> |

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| | | laboratory reporting. The surveillance programme is appropriate to the acuity, risk and needs of the residents. There has been one outbreak of norovirus in July 2014, which involved seven residents and was resolved within days. The DHB was notified and involved. |
| Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised. | FA | There is practice around restraint minimisation. The clinical nurse manager oversees the restraint process within the facility. Each of the three wings has a dedicated restraint champion who reports to the clinical manager. There are policies around restraint, enablers and the management of challenging behaviours in place to guide staff. The service currently has four hospital residents assessed as requiring restraint in the form of bedrails. There are nine residents (one rest home and eight hospital), who are voluntarily using enablers, all of which are bedrails. The service has alternative systems available so that staff can use restraint as a last resort strategy. Care plans include reference to the use of restraint or enablers. |

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) |
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| <p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p> | PA Low | <p>All residents are assessed on admission. Initial and long-term care plans are then completed following assessment and reviewed in a timely manner. There have been six residents admitted since 1 July 2015 (all directly from DHBs). Only one of six residents had a completed InterRAI assessment within 21 days. All InterRAI information was requested by the provider following admission. The provider had completed all their usual assessments following admission except for the InterRAI assessment.</p> | <p>Five of six residents admitted since 1 July 2015 did not have an InterRAI assessment completed within 21 days of admission. The service had only recently received InterRAI information from DHBs for two of the five residents. Advised that the service was waiting for previous InterRAI information from the DHBs, for three of the five residents.</p> | <p>Ensure all residents admitted to the facility have an InterRAI assessment completed within 21 days of admission.</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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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| No data to display |
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End of the report.