

Radius Residential Care Limited - Radius Peppertree Care Centre

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Radius Residential Care Limited

Premises audited: Radius Peppertree Care Centre

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

Dates of audit: Start date: 24 May 2016 End date: 25 May 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 60

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	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 Peppertree is part of the Radius Residential Care Group. The service provides hospital and rest home level of care for up to 62 residents. On the day of the audit, there were 60 residents. The facility manager has been in the role for three years and is supported by a clinical nurse manager, with experience in aged care.

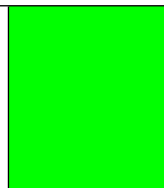
This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews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

The service has addressed five of five shortfalls from their previous certification around admission InterRAI assessments, care plans, documented interventions, short-term care plans, and medication administration.

There were no areas of improvement identified at this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

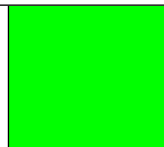


Standards applicable to this service fully attained.

Residents and families interviewed state they are kept informed on all health related matters. Information on the complaints process is made available to residents/family at the time of admission and is displayed in the entranceway. All concerns and complaints have been managed appropriately. The complaints register is up-to-date.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Standards applicable to this service fully attained.

Radius Peppertree is part of the Radius group with organisational-wide processes in place to monitor performance. Suitably trained personnel manage the service. There is an implemented quality risk system in place. Quality/infection control/health and safety meetings are used to monitor quality activities such as internal audits, complaints/concerns, health and safety, accidents/incidents, infection control and restraint. There is a human resource manual to guide practice. There is an annual education programme, which covers mandatory requirements. Staffing rosters were sighted and residents, families and staff confirm there are adequate staff on duty.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Registered nurses are responsible for each stage of service provision. Initial assessments, InterRAI assessments and care plans were developed within the required timeframes. The sample of residents' records reviewed provided evidence that the provider has systems in place to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed with the resident and/or family/whānau input. Care plans are evaluated six monthly. The general practitioner reviews the residents at least three monthly.

Medicines are managed, and policies reflect legislative requirements. Staff responsible for the administration of medicines complete education and medicines competencies.

The activities programme provides varied options and activities that meet the abilities of each resident group. Activity plans are individualised. Community activities are encouraged and van outings arranged.

All food is cooked on site by the qualified cook. A dietitian has reviewed the menu. All residents' nutritional needs are identified, documented and choices provided. Food and fridge temperatures are recorded.

Safe and appropriate environment

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

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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The service has policies and procedures to appropriately guide staff around consent processes and the use of enablers. There are currently two residents using enablers and six residents using restraint. Residents with enablers have voluntarily signed consents. Staff receive training in restraint and managing challenging behaviour as part of the annual training plan.

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.
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An infection control policy includes surveillance activities. Infections are reported and collated monthly. Infections and internal audit outcomes are discussed as part of the quality/infection control/health and safety meetings. Information is available to staff. The surveillance programme is appropriate to the size and complexity of the facility.

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	17	0	0	0	0	0
Criteria	0	40	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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>There is a policy to guide practice, which aligns with Right 10 of the Code. The facility manager leads the investigation of non-clinical and clinical concerns/complaints in consultation with the regional manager (registered nurse). All concerns and complaints are entered into an on-line complaints register. There has been one written complaint in 2015 and one verbal concern to date for 2016. Appropriate action has been taken within the required timeframes and to the satisfaction of the complainants. One HDC complaint (dated 2013) has now been closed-out.</p> <p>Complaints forms are visible in the main entrance. Management operate an 'open door' policy. Families and residents (two hospital including one person under 65 years of age and five rest home residents) confirm they are aware of the complaints process and that management are approachable. The complaints procedure is provided to residents in the information pack on entry.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed of an accident/incident and forms reviewed identify that family have been notified following resident incidents. The clinical manager and facility manager advised that family are kept informed and this was confirmed on interview with three hospital residents' family members. Two monthly resident meetings are held. Resident meetings provide residents with an opportunity to feedback on the services provided and ensure they are kept informed on facility matters. Residents and relatives receive a facility</p>

<p>provide an environment conducive to effective communication.</p>		<p>newsletter every two months and an organisational newsletter 'The Orbiter' three monthly. There is access to interpreter services.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Radius Peppertree provides rest home and hospital level of care for up to 62 residents. There are 20 rest home beds, 20 dual-service beds (located within the rest home wing) and 22 hospital level beds. On the day of audit, there were 23 rest home level and 37 hospital level residents, including 15 hospital residents in dual-purpose beds. There were one rest home and three hospital younger person residents under 65 years of age (YPD). All other residents were under the ARCC. There were no residents under the medical component or on respite care on the day of audit.</p> <p>Radius has an organisational philosophy, which includes a vision and mission statement. There is a strategic business plan for 2014 – 2017 that has had an annual review. Ongoing goals are reviewed regularly. Quality goals achieved over the last year included: 1) Increased attendance at training, due to the implementation of training days and a roster to ensure all staff attend mandatory education. 2) The use of the Radius 'Raise Up communication programme' that focuses on communication and improving English for those with English as a second language. 3) Review of the recreational programme. 4) Resident mobility-status, in pictorials in all bedrooms. 5) Patient boards in both rest home and hospital nurses stations for quick reference of resident status/supports. 6) The installation of a new call-bell system with connection to sensor mats, and the purchase of new air-alternating mattresses.</p> <p>The facility manager (previously an enrolled nurse) has been in the role three years and has experience in aged care management. A clinical manager (registered nurse) appointed in September 2014 supports her. The clinical manager has had clinical experience within the district health board and the aged care environment. A regional manager visits two-three times weekly and as required supports the management team.</p> <p>The facility manager has maintained at least eight hours annually, of professional development related to managing an aged care facility.</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</p>	<p>FA</p>	<p>Radius Peppertree has implemented a quality and risk management system.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The operations management team at head office regularly develop and review policies.</p> <p>The content of policy and procedures are detailed to allow effective implementation by staff. Staff interviewed (one RN and four healthcare assistants – HCAs) confirm they are made aware of new/reviewed policies.</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>There are monthly combined quality/infection control and health and safety meetings where monthly quality data is discussed including infections, accidents and incidents, health and safety, restraints and enablers, concerns and complaints and audit outcomes. Other facility meetings include RN meetings, night shift meetings, full staff meeting and food service meetings.</p> <p>An internal audit programme includes clinical and non-clinical audits. For audits with outcomes below 95%, a corrective action plan is raised and discussed at the facility meetings. The facility manager, where required, has signed off corrective action plans.</p> <p>Resident/relative satisfaction surveys are completed annually in July. Through resident meetings, results were collated and fed back to participants. A separate activities survey was completed in February 2016 with 80% satisfaction with activities provided.</p> <p>Benchmarking of quality indicators occurs within the Radius organisation. The Radius Peppertree facility receives feedback on its performance through the Radius on-line quality system and this is communicated to staff through meetings and a display of quality data information.</p> <p>There is an implemented health and safety, and risk management system in place including policies to guide practice. The facility manager oversees health and safety. Two health and safety representatives have attended health and safety training. The committee is representative of all service areas and actively involved in the review of the hazard register and accident/incidents. The service has achieved tertiary level of the ACC workplace safety-management practices in September 2015.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Falls risk assessments are completed. Interventions include sensor mats, intentional rounding, physiotherapist assessments and post-falls assessments.</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</p>	<p>FA</p>	<p>Twelve accident/incident forms for the month of March 2016 were reviewed. There has been RN notification and clinical assessment completed in a timely manner. Accidents/incidents were recorded in the resident progress notes. There is documented evidence family/whānau had been notified.</p> <p>The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.</p> <p>Discussions with the regional manager and facility manager confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>

in an open manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Six staff files reviewed (facility manager, three RNs and two HCAs) contained all relevant employment documentation and completed orientations with relevant information for safe work practice. Current practising certificates were sighted for the clinical manager, RNs and allied health professionals. Staff interviewed believed new staff were adequately orientated to the service on employment. Performance appraisals are up to date.</p> <p>The 2015 annual education planner covered all the compulsory training requirements. The 2016 education sessions have commenced. Four half study-days are scheduled throughout the year that cover all the mandatory requirements. Two sessions of each study day is held and staff are allocated to attend one of the sessions. An additional 'catch up' study day is provided for night staff.</p> <p>All RNs, some senior HCAs and the DTs have a current first aid certificate. Registered nurses are supported to attend external education. Care staff are supported to achieve the aged care qualifications through weekly tutorials delivered by an external aged care assessor.</p> <p>Clinical staff complete competencies relevant to their role.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. There are two RNs (one in the rest home and one in the hospital) on morning and afternoon shifts and one RN on night duty to cover both areas, with three HCAs. The facility manager and clinical manager are on-site Monday to Friday with shared on call.</p> <p>The HCAs, residents and relatives interviewed inform there are sufficient staff on duty at all times.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>All medication is managed appropriately in line with required guidelines and legislation. Registered nurses and senior HCAs (for rest home residents only), administer medications and have completed annual education and competencies. Registered nurses have completed syringe driver competencies. All medications are checked against the medication chart on delivery and any discrepancies fed back to the supplying pharmacy. All medications were within expiry dates.</p> <p>There were no self-medicating residents. Standing orders are not used. Medication fridge temperatures are checked daily and are within acceptable ranges.</p> <p>Ten medication charts were reviewed and prescribing met the legislative requirements. The GP has reviewed the medication charts at least three monthly. Corresponding signing sheets were reviewed and evidenced</p>

		medications were administered as prescribed. The previous finding around medication administration has been addressed.
<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>	FA	<p>There is a cook, kitchenhand and tea cook on duty each day. All baking and meals are prepared and cooked on site. There is an organisational four-week menu, which has been reviewed by a dietitian. Meals are served from a bain-marie to the rest home dining room and they are delivered in hot boxes to the hospital dining room.</p> <p>The cook receives a dietary notification for new residents and is notified of any changes, including weight loss. Resident's likes and dislikes are known and alternatives are offered. Each meal has daily end-cooked temperatures taken and recorded. All foods are dated labelled in fridges, freezers and chiller. There is daily fridge and freezer monitoring. The service has purchased a new freezer, double door chiller and bain-marie. Staff are observed wearing appropriate protective wear. Chemicals are stored safely when the kitchen is unattended. There is an opportunity for residents to feedback on the food service at resident meetings and through satisfaction surveys. All food services staff have attended food safety and chemical safety training.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Long-term care plans in the five files reviewed were up-to-date and described the resident's current health status, supports and needs to meet the resident's desired goals. The outcomes of assessments are reflected in the care plans. The previous finding around care plans has been addressed. Short-term care plans are used for short-term needs and changes in health status.</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>	FA	<p>When a resident's condition alters, the registered nurses initiate a review and if required a GP consultation or referral to the appropriate health professional. Residents and relatives interviewed, state the residents' needs are being met. Significant events and communication with families are well documented on the communication with family form. Appropriate interventions had been implemented and documented for changes in health. The previous finding around interventions to meet the resident's needs has been addressed.</p> <p>Adequate dressing supplies and continence products were sighted. Each wound had a wound assessment and care plan with ongoing evaluations and dressing changes at the documented frequency. The previous finding around wound assessments has been addressed. There were six hospital level residents with wounds, and ten rest home residents with wounds, including two chronic ulcers. There were no pressure injuries on the day of audit. The GP and wound nurse specialist had been involved where applicable.</p> <p>Specialist continence advice is available as needed and the clinical nurse manager could describe this.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The recreation officer is a qualified diversional therapist who has been in the role for two years. The rest home/hospital activity programme is being implemented Monday to Friday from 9am to 4pm.</p> <p>The programme is planned a month in advance and is designed to meet the recreational preferences and abilities of the residents. Activities include one-on-one time, group activities, community outings and entertainment. There are volunteers that assist with the programme. Residents are encouraged to maintain community links such as friendship club. There are weekly church services on-site.</p> <p>Activity assessments are completed for residents on admission. The activity plan is incorporated into the individualised care plan. The activity plans are reviewed at the same time as the care plans, with resident/family involvement.</p> <p>Residents have the opportunity to feedback on the programme through resident meetings and surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>An RN reviewed all initial care plans within three weeks of admission and long-term care plans developed. The long-term care plans were evaluated at least six monthly or if there is a change in health status in two of five resident files reviewed. One rest home resident and two hospital residents had not been at the service six months. There is a three monthly review by the GP. The residents and relatives interviewed confirm they are involved in the review of care plans. Relatives interviewed confirm they are invited to participate in care plan reviews.</p> <p>Short-term care plans were evaluated at regular intervals with ongoing problems transferred to the long-term care plan. The previous finding around evaluations has been addressed.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness that expires on 5 April 2017.</p>
<p>Standard 3.5:</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (clinical nurse manager) collates information obtained through surveillance to determine infection</p>

<p>Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>control activities and education needs in the facility. Definitions of infections are appropriate to the complexity of service provided. Trends are identified and quality initiatives put in place. Infection control data is collated monthly and reported at the quality/health and safety/infection control meetings. Healthcare assistants interviewed confirm infection control and surveillance data is discussed at staff meetings and information was sighted in the staff room. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes restraint procedures. The policy identifies that restraint is used as a last resort. There were three residents with enablers (bedrails) in use. The resident has voluntarily signed enabler consent. Enablers were linked to the care plans. The clinical nurse manager is the restraint coordinator. Annual training on restraint is provided. The restraint approval committee meet monthly and review the use of restraints. There were three residents with restraints (two bedrails and three lap belts). Risks have been identified with the use of restraint and restraint monitoring in place. Restraint/enablers are discussed at the clinical 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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.