Radius Residential Care Limited - Radius Kensington

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

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; Dementia care
Dates of audit:	Start date: 23 May 2017 End date: 24 May 2017

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: 93

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Radius Kensington (Kensington) is part of the Radius Residential Care Group. Kensington cares for up to 97 residents requiring hospital (geriatric and medical), rest home, dementia care and residential disability (physical) level care. On the day of the audit there were 93 residents.

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 facility manager has been in the role for four years and has previous experience in aged care management. She is supported by a clinical manager and the Radius regional manager.

Residents and family interviewed spoke positively about the service provided.

Both of the two shortfalls identified at the previous audit have been addressed. These were around wound documentation and follow-up of incidents.

This audit has identified one area requiring improvement around medication management.

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.

Discussions with families identified that they are fully informed of changes in health status. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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.

A facility manager and clinical manager are responsible for the day-to-day operations. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities, including an audit schedule are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings are held regularly and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An education and training programme has been implemented with a current plan in place. Comprehensive employment processes are adhered to. An orientation programme is in place for new staff. A roster provides sufficient staff for the effective delivery of care. Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

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 medium or high risk and/or unattained and of low risk.

Initial assessments and risk assessment tools are completed by the registered nurses or enrolled nurses on admission. Registered nurses and enrolled nurses are responsible for care plan development with input from residents and family. Care plans document individualised intervention to meet residents assessed needs. Planned activities are appropriate to the residents' assessed needs and abilities and residents advised satisfaction with the activities programme. There are medications policies and procedures in place line with legislation and current regulations. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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.

A current building warrant of fitness is posted in a visible location.

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.

The service has a philosophy to minimise the use of restraint and employs a variety of techniques to achieve this. At the time of the audit there were three residents with restraint and nine with enablers. Enabler use is voluntary.

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.

Kensington has an infection control programme that complies with current best practice. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	0	1	0	0
Criteria	0	36	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy and procedure in place. The complaints procedure is provided to residents and their family within the information pack at entry. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings and complaint forms. Information on the complaints forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception. Sixteen complaints were made in 2016 and seven complaints have been received in 2017 year to date. All complaints reviewed have been signed off as resolved. A review of the complaints register evidences that the appropriate actions have been taken in the management and processing of these complaints. There has been one complaint to the DHB around alternative food choices. Resident satisfaction with food/meals was at 70% satisfaction rate of either being good or very good from the satisfaction survey completed in March 2017. Residents, relatives and HCAs interviewed commented about the kitchen's willingness to provide alternative foods to meet resident preferences.
Standard 1.1.9: Communication Service providers communicate effectively with	FA	Seven hospital residents, including one resident under an ACC contract, one younger persons with disability (YPD), two on long-term chronic conditions (LTCC) and three rest home, (including one resident on convalescent care) interviewed, stated they were welcomed on entry and were given time and explanation about the services and procedures. A sample of fourteen incident reports reviewed evidenced recording of family notification. The previous certification audit finding has been addressed. Eleven relatives interviewed (seven hospital and four

consumers and provide an environment conducive to effective communication.		dementia care) confirmed they are notified of any changes in their family member's health status. The facility manager, clinical manager, three registered nurses (RNs) and five healthcare assistants (HCA), four who work in the rest home/hospital on the AM and PM shifts and one who works in the dementia unit on the AM shift can identify the processes that are in place to support family being kept informed. 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. A specific introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	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 97 residents. On the day of the audit there were 93 residents, 22 rest home, 53 hospital and 18 dementia level residents. This includes five hospital residents on younger person with disability (YPD) contracts, three hospital residents on long-term support – chronic health conditions (LTS – CHC) contracts, five hospital residents funded by ACC who are under 65 years old and one rest home resident on a convalescent care contract. Seventy-six beds are dual-purpose. The Kensington business plan April 2017 to March 2018 is linked to the Radius Residential Care group strategies and business plan targets. The mission statement is included in information given to new residents. An organisational chart is in place. Comprehensive quarterly reviews are undertaken to report on achievements towards meeting business goals. The facility manager is well trained and experienced and has been in the role for four years. She is supported by a clinical manager, who has been in the role for one year. The regional manager also supports the facility manager in the management role and was present during the days of the audit. The facility manager has maintained more than eight hours of professional development activities related to managing an aged care facility.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects	FA	An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the manager's and staff reflects their involvement in quality and risk management processes. Resident meetings are bi-monthly and meeting minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The clinical managers group reviews the service's policies at a national level, every two years with input from facility staff. Clinical guidelines are in place to assist care staff. The quality monitoring programme is designed to monitor contractual and standards compliance, the quality of

continuous quality improvement principles.		service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflected actions being implemented and signed off when completed. Health and safety policies are implemented and monitored by the health and safety committee. The health and safety representative (office manager) interviewed, confirmed her understanding of health and safety processes including recent law changes. She has completed the external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Radius has achieved tertiary level ACC Workplace Safety Management Practice. Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Incidents are included in the Radius key performance indicators (KPIs). There is a discussion of incidents/accidents at monthly staff/quality meetings including actions to minimise recurrence. A review of fourteen incident/accident forms identifies that forms are fully completed and include follow-up by a registered nurse (RN). Neurological observations are carried out for any suspected injury to the head. All incidents reviewed had documented analysis to identify opportunities to improve service delivery and manage risk. The previous certification audit finding has been addressed. Discussions with the facility manager and regional manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications with examples of situations provided. A letter from the Ministry of Justice in December 2016 states there would be no further action taken in regards a coroner's inquest re a sudden death in August 2016. Three section 31 incident notification forms were completed in January, April and May 2017 (all sighted) in relation to three pressure injuries (all stage three).
Standard 1.2.7: Human Resource Management Human resource management processes are	FA	Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one clinical manager, one RN, two healthcare assistants (HCAs), one kitchen manager and one activities coordinator) include a comprehensive recruitment process, which includes: reference checking, signed employment contracts, job descriptions, police checks, completed orientation programmes and annual performance appraisals. A register of RN and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice. Staff are required to complete

conducted in accordance with good employment practice and meet the requirements of legislation.		written core competencies during their induction. These competencies are repeated annually. There is an implemented annual education and training plan that exceeds eight hours annually. All staff participate in continuing education relevant to physical disability and young people with physical disabilities. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. Four of twelve RNs have completed their interRAI training. There are six HCAs who work in the dementia unit. All six have completed the ACE dementia NZQA standards.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A policy is in place for determining staffing levels and skills mix for safe service delivery. There is a full-time facility manager and clinical manager who work from Monday to Friday. The hospital/rest home beds are split into three units: unit A has 28 residents, unit B 17 residents and unit C has 30 residents. There are two RNs on duty in the AM shift, three on the PM shift and one on the night shift in the rest home/hospital area. The RN's are supported by adequate numbers of HCAs. There are four HCAs on duty in the AM shift, two on the PM shift and one on the night shift in both unit's A and C. In unit B, there are two HCAs on duty in both the AM shift and PM shift. There is an additional HCA floater in the AM and PM shift available to assist where needed. In the dementia unit, there are two HCAs on duty in both the AM shift and PM shift and one on the night shift. Staff working on the days of the audit, were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. The RNs on duty in the rest home/hospital area also cover the dementia unit. In the dementia unit, staff state that overall, the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed report there are sufficient staff numbers.
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.	PA Moderate	Medications are checked against the doctor's medication profile on arrival from the pharmacy by a registered nurse. Any mistakes by the pharmacy are regarded as an incident. Medications are stored safely in the treatment room and no expired medications are on site. Not all eye drops were dated when opened. Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. A registered nurse was observed safely and correctly administrating medications. Not all prescribed medications on charts reviewed have been signed as administered. Resident medication charts are identified with demographic details and photographs. The medications fridge is monitored daily. All 12 medication charts sampled had allergies (or nil known) and indications for use for 'as required' medications documented. All medications had been reviewed by a GP at least three-monthly, where the resident had been at the service for longer than three months. There were eight residents who self-administered medications. All had a current competency assessment.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The service has a large workable kitchen. The kitchen and the equipment are well maintained. The service employs sufficient kitchen staff to provide meal services over seven days a week. There are rotating four weekly menus in place that are designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed. There was evidence that likes and dislikes are catered for, including last minute requests. Food safety information and a kitchen manual are available in the kitchen. The food safety plan was approved by the Ministry of Primary Industries in March 2017. Food served on the day of audit was hot and well presented. The residents interviewed spoke positively about meals provided and they all stated that they are asked by staff about their food preferences and that these were met. Alternatives are provided when a resident does not like the meal provided. The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use-by date expires. All food is stored and handled safely. Food temperatures are recorded. The kitchen is clean. Kitchen staff have been trained in safe food handling.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Wound care plans, infection control plans, fluid balance management plans, repositioning charts, restraint monitoring, intentional rounding charts and pain management plans are evident. In files reviewed the use of short-term care plans was evident. The resident on a convalescent care contract have a short-stay care plan and the DHB requirements are documented. In all files sampled and following observation and interviews with staff and residents; the residents are receiving care that meets all their needs. The GP interviewed stated the facility applied changes of care advice immediately and was complimentary about the quality of service delivery provided. Residents' needs are assessed prior to admission and residents' primary care is provided by the facility GPs unless the resident chooses another GP. The resident on an YPD contract has a current needs assessment. Dressing supplies are available and a treatment room is stocked for use. 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. Specialist continence advice is available as needed and a physiotherapist visits the facility for a minimum of six hours weekly. A contracted dietitian is available and provides input when this is required. Wound assessment and wound management plans are in place for 13 wounds including ulcers, skin tears and surgical wounds and five pressure injuries (one stage 1, one stage 2, one stage 3 and two unstageable). There is evidence in files of the wound specialist referrals. Wound care is completed within timeframes. These are

		improvements since the previous audit.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There are three activities coordinators who provide a programme in the rest home/hospital and in the dementia unit. Healthcare assistants provide activities in the dementia unit using a wide variety of equipment according to the plan developed by the activities staff when activities staff are not present. All recreation/activities assessments and reviews sampled are up-to-date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge and throughout the facility including healthcare assistant initiated activities in the dementia unit. Residents have a comprehensive assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career and family. In the dementia unit, the programme is flexible. Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Resident files of younger residents and interviews with activity staff and residents describe individualised and specific activities to meet the needs of younger residents. In addition to regular activities there is a monthly group for younger residents where the residents determine the activity. Recent activities include a pizza night and a movie night. All residents and family members interviewed state that activities are appropriate and varied and are positive about the programme. Five long-term resident files reviewed identified that the individual activity plan is reviewed at the time of the care plan review.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Five of six initial care plans sampled have been evaluated by the registered nurses within three weeks of admission (one resident had not been at the service for three weeks). The long-term care plans sampled have been evaluated at least six monthly or earlier if there is a change in health status. There is at least a three-monthly review by the GP. All changes in health status are documented, followed up and where required the care plan updated. Care plan reviews are signed by a registered nurse. Short-term care plans sampled have been evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.
Standard 1.4.2: Facility Specifications	FA	A current building warrant of fitness is posted in a visible location.

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory, skin and infections that do not require antibiotics. This data is analysed and acted upon and reported to the facility meetings. Monthly data was seen in staff areas. The service submits data monthly to Radius head office where benchmarking is completed. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a restraint minimisation and safe practice policy that is applicable to the service and has recently been updated by the organisation. The aim of the policy and protocol is to minimise the use of restraint and any associated risks. There were three residents using restraint and nine residents using enablers at Kensington. All enablers have a consent signed by either the resident or the activated EPOA.

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)
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	All medications are kept in the treatment room. There are three medication trolley’s (one for the dementia unit and two for the rest home/hospital). On two of the three trolleys, all eye drops had been dated when they were opened. Staff who administer medication complete an annual competency assessment and the registered nurse witnessed that administering medication followed correct protocol. However not all prescribed medications were signed as administered.	(i) Three of seven eye drops in the ‘orange’ medication trolley had not been dated when they were opened. (ii) Seven of twelve medication administration records sampled had occurrences where prescribed medications had not been signed	(i) Ensure all eye drops are dated when they are opened. (ii) Ensure medications are administered as prescribed and the administration record signed to demonstrate

			as administered.	this. 60 days

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.

No data to display

End of the report.