

Radius Residential Care Limited - Radius Potter Home

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 Potter Home

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

Dates of audit: Start date: 7 March 2018 End date: 8 March 2018

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: 55

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 Potter Home is part of the Radius Residential Care Group. The service provides hospital services (medical and geriatric), rest home care and residential disability services (physical) for up to 57 residents. On the day of the audit there were 55 residents.

The facility manager has been in the role for five years and has previous experience in aged care management. She is supported by an acting clinical manager and the Radius regional manager.

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. 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.

Residents and family interviewed spoke positively about the service provided.

The shortfall identified around interRAI assessments at the previous audit have been addressed.

This audit has identified one area requiring improvement around infection surveillance.

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.
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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.

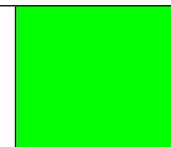
Organisational management

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.
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A facility manager and acting 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.

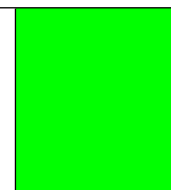


Standards applicable to this service fully attained.

Initial assessments and risk assessment tools are completed by the registered 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 in 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.

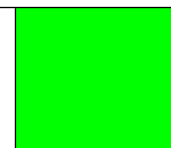


Standards applicable to this service fully attained.

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 six residents with restraint and seven 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.		Some standards applicable to this service partially attained and of low risk.
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Potter Home has a defined surveillance programme with monthly reporting by the infection control coordinator. There is robust review of antibiotic use and documented follow-up of adverse trends.

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	1	0	0	0
Criteria	0	38	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
<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 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 form includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception.</p> <p>Four complaints were received in 2017 and two complaints have been received in 2018 year-to-date.</p> <p>The two complaints reviewed for 2018, include follow up actions taken in the management and processing of these complaints. A separate meal satisfaction survey and internal review was undertaken as a result of complaints, resulting in a kitchen restructure.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Eight residents, (including four hospital, two rest home and two younger person disabled) interviewed, stated they were welcomed on entry and were given time and explanation about the services and procedures. A sample of six incident reports reviewed evidenced recording of family notification. Six relatives interviewed (four hospital and two rest home) confirmed they are notified of any changes in their family member's health status.</p> <p>The facility manager, acting clinical manager, one registered nurse (RN), one enrolled nurse (EN) and five healthcare assistants (HCA) interviewed, identified that processes are in place to support family being kept</p>

<p>provide an environment conducive to effective communication.</p>		<p>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.</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>Potter Home is part of the Radius Residential Care group. The service provides hospital services (medical and geriatric), rest home care and residential disability services (physical) for up to 57 residents. On the day of the audit, there were 55 residents, (17 rest home, 28 hospital [including two under a long-term support – chronic health conditions (LTS – CHC) contract and one ACC] and 10 residential disability residents (two rest home level and eight hospital level). Six beds are dedicated as dual-purpose.</p> <p>Radius potter home has a documented business and quality plan that references the Health and Disability Sector Standards. Monthly reporting by the facility manager to the operations manager is linked to the business and quality plan. 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 goals set by the business and quality plan.</p> <p>The facility manager is an experienced RN and manager and has been in the role for four years. She is supported by an acting clinical manager (covering the clinical manager who is currently on leave) and a quality coordinator. 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.</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>	<p>FA</p>	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the operations manager. A review of team meetings evidences comprehensive reporting and discussion of a wide range of quality data, incidents and accidents, infection control, and health and safety.</p> <p>Discussions with the managers and staff reflects their involvement in quality and risk management processes. Resident meetings are monthly and meeting minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff.</p> <p>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.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting, using the new electronic system. The facility has implemented the Radius processes to collect, analyse and</p>

		<p>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.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. 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.</p> <p>Radius has achieved tertiary level ACC Workplace Safety Management Practice.</p> <p>Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>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). The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>A review of six falls related resident 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.</p> <p>Discussions with the management team confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications, with examples of situations provided. One section 31 incident notification form was completed in relation to a pressure injury (stage three).</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</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (two RNs, one EN, and three healthcare assistants), include a documented recruitment process, including: 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 written core competencies during their induction. These competencies are repeated annually.</p> <p>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.</p>

requirements of legislation.		Registered nurses are supported to maintain their professional competency. Three of six RNs have completed their interRAI 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>A policy is in place for determining staffing levels and skills mix for safe service delivery. There is a full-time facility manager and acting clinical manager who work from Monday to Friday. A quality coordinator (enrolled nurse) works four days a week.</p> <p>There is a registered nurse (RN) on duty each shift, plus an additional RN 10am to 7pm each day.</p> <p>The staff are rostered to the hospital or the rest home, they are allocated groups of residents each shift.</p> <p>For the hospital (36 residents on the day of audit); AM; five health care assistants (HCA) (four long and one short shift). PM; four HCA (four long shifts).</p> <p>For the rest home (19 residents, including the YPD wing, on the day of audit); AM three HCA (two long and one short shift) PM three HCA (two long and one short shift).</p> <p>For nights; three HCA.</p> <p>Staff state that overall, the staffing levels are satisfactory and that the managers provides good support. Residents and family members interviewed report there are sufficient staff numbers.</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>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.</p> <p>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 administering medications.</p> <p>Resident medication charts are identified with demographic details and photographs. The medications fridge is monitored daily. All 10 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.</p> <p>There were six residents who self-administered medications, including one YPD resident. All had a current competency assessment and the RN checks each medication round to ensure medications are taken as prescribed.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service continues to provide all meals cooked on-site from the fully functional kitchen. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. A food service plan is in development with the local authority.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>In all five files sampled (and following observation and interviews with staff and residents), the residents are receiving care that meets all their needs. The GP interviewed was complimentary about the quality of service delivery provided. Wound care plans, infection control plans, fluid balance management plans, repositioning charts, restraint monitoring, intentional rounding charts and pain management plans were evident. In files reviewed the use of short-term care plans was evident. Residents' needs are assessed prior to admission and residents' primary care is provided by the facility GPs unless the resident chooses another GP. The YPD resident file reviewed has a current needs assessment.</p> <p>Dressing supplies are available, and a treatment room is stocked for use.</p> <p>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>Specialist continence advice is available as needed and a physiotherapist visits the facility for a minimum of six hours weekly. A dietitian is available and provides input when this is required.</p> <p>Wound assessment and wound management plans are in place for seven residents with wounds (12 wounds in all). There was one pressure injury and the rest were skin tears. There is evidence in files of the wound specialist referrals. Wound care is completed within timeframes.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	<p>FA</p>	<p>An activities coordinator is employed full time to operate the activities programme for all residents. She is studying for the diversional therapy qualification.</p> <p>Each resident has an individual activities assessment on admission and from this information, an individual activities plan is developed as part of the care plan by the registered nurses with input from the activities staff.</p> <p>On the day of audit, residents were observed being actively involved with a variety of activities. Residents have a comprehensive assessment completed over the first few weeks after admission, obtaining a complete history of</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>past and present interests, career and family. Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life.</p> <p>Resident files of younger residents and interviews with activity staff, describe individualised and specific activities to meet the needs of younger residents including; men's club, stroke club, forget-me-not day services, and lunch trips. Two YPD residents interviewed said the activities were very good.</p> <p>All residents and family members interviewed state that activities are appropriate and varied and are positive about the programme.</p> <p>Long-term resident files reviewed identified that the individual activity plan is reviewed at the time of 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>	<p>FA</p>	<p>Initial care plans sampled have been evaluated by the registered nurses within three weeks of admission. 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.</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>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location. There is a seven bed YPD dedicated wing. This wing has its own lounge and dining room and there is easy access to outside areas via ramps.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives,</p>	<p>PA Low</p>	<p>The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory, skin, only infections that require antibiotics are collected and reported. 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.</p>

<p>priorities, and methods that have been specified in the infection control programme.</p>		<p>There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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 six residents using restraint (four bedrails and two lap belts) and seven residents using enablers (five bedrails and two lap belts). Files reviewed for one resident with an enabler and one resident with restraint, both had a consent signed by either the resident or the activated EPOA and care plan interventions.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	PA Low	The infection control coordinator has a very robust process with regard to collection of infections and reviewing antibiotic use. Results are communicated to GPs and staff. There is evidence that results of infection control statistics are used to develop ongoing infection control practices, such as training for staff and individualised resident interventions. Only infections that result in antibiotic use are collected.	The service only collects and reports infections that require antibiotic use. Infection surveillance is not gathered against standardised definitions and therefore infection stats are out.	<p>Ensure all infections are identified as per standardised definitions.</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.

No data to display

End of the report.