

Radius Residential Care Limited - Radius Hampton Court

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Radius Residential Care Limited

Premises audited: Radius Hampton Court

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

Dates of audit: Start date: 27 June 2019 End date: 28 June 2019

Proposed changes to current services (if any): There were ten large rest home rooms assessed for dual-purpose as part of this audit. The ten rooms have sufficient space for the safe delivery of hospital level care residents. Seven of the ten rooms in the rest home wing (Kensington) would be better suited for standing hoist only and the other three rooms in the hospital wing can accommodate the use of a full hoist.

Total beds occupied across all premises included in the audit on the first day of the audit: 44

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 Hampton Court is owned and operated by Radius Residential Care Limited. The service provides care for up to 45 residents requiring rest home and hospital level of care. On the day of the audit there were 44 residents. The service is managed by a facility manager/registered nurse who has experience in aged care management. She is supported by a Radius regional manager and a clinical nurse manager. Residents, relatives and the GP interviewed spoke positively about the service provided at Hampton Court.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents' and staff files, observations and interviews with residents, relatives, staff, management and general practitioner.

This audit has identified an area for improvement around neurological observations.

The service has been awarded a continuous improvement around falls reduction and waste 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.
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The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review process. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

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 clinical nurse 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 Radius key performance indicators, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings are held bi-monthly 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. An orientation programme is in place for new staff. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate coverage

for the effective delivery of care. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior medication competent healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

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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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are nineteen rooms with ensembles. All other rooms have hand basins and six rooms have toilet ensembles. There are sufficient communal showers/toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. There is an approved evacuation scheme and emergency supplies for at least three days. There is at least one staff member on duty at all times with a first aid certificate.

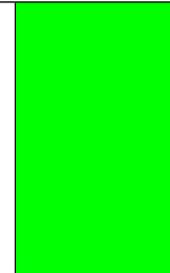
Restraint minimisation and safe practice

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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint if required. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation and challenging behaviour. At the time of the audit there were no residents using restraints and one resident using an enabler. The facility has been restraint free since 2017.

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.

There are infection control management systems in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. The infection control coordinator has attended external education. Relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (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	44	0	1	0	0	0
Criteria	2	90	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with six care staff, including three healthcare assistants (HCA), two registered nurses (RN) and one activity coordinator, confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Six residents (two rest home and four hospital) and five relatives (two rest home and three hospital level) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice. Staff receive training on the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (two rest home and five hospital including one ACC and two long-term chronic health care). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. Four out of seven files reviewed had advanced directives.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in their relative's care and decisions. The resident files include information on residents' family/whānau and chosen social networks.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activity programme includes opportunities for residents to attend events outside of the facility including RSA, churches of resident choice, Napier pipe band events and the library. Interviews with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Residents are involved in fundraising for charities including child cancer society and pink ribbon breakfast.
<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>The service has a complaints policy that describes the management of the complaints process. A complaints procedure is provided to residents within the information pack at entry. Feedback forms (compliments, suggestions and complaints) are available at the main entrance to the facility. There is a complaint register that includes relevant information regarding the complaint. There have been two internal complaints since the last audit which have been acknowledged and addressed appropriately and within the required timeframes.</p> <p>The service has received a request from HDC to provide information in relation to an HDC complaint received. The regional manager and facility manager are in the process of responding to the HDC request.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	The service provides information to residents that includes the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident during the admission process. There is a code of rights poster in English and Māori displayed in the main entrance. Residents and relatives interviewed stated they are well informed about the Code of Rights. Bi-monthly resident meetings provide the opportunity to raise concerns.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Staff sign a non-disclosure declaration on employment. Care staff were observed to respect a resident's privacy by knocking on doors before entering. There were privacy locks on communal toilet/showers. Staff education and training on abuse and neglect has been provided within the last two years.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Radius Hampton has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. There is one resident who identified as part-Māori at the time of audit. The resident file reviewed included a Māori health plan which aligned with the cornerstones of Māori health. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Māori consultation is available through a local Māori kaumātua and the local DHB Māori health services.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values. Interdenominational church services are held.</p>
<p>Standard 1.1.7:</p>	FA	<p>Staff job descriptions include responsibilities, and staff sign a copy on employment. The full staff meetings and</p>

<p>Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>clinical meetings hold discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the facility manager, clinical nurse manager and RNs confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The Radius quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. Policies and procedures have been reviewed and updated at organisational level and are available to staff. Staff meetings and resident meetings have been conducted. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the facility manager, clinical nurse manager and nursing staff. There are implemented competencies for HCAs and RNs. There are clear ethical and professional standards and boundaries within job descriptions. The service has focused on building relationships with the DHB including the provision of short-term contracts such as the Engage contract. There are weekly visits by the gerontology nurse specialist who supports the staff and provides training as required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the health status of their relative. Fifteen resident incidents/accidents reviewed for the month of May 2019 confirmed this. Resident meetings are held bi-monthly and are open to family to attend. The service produces regular newsletters that keep family updated on facility matters and news. The facility manager and clinical nurse manager have an open-door policy. If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</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</p>	<p>FA</p>	<p>Radius Hampton Court is part of the Radius Residential Care group. The service currently provides rest home, hospital level care and medical services for up to 45 residents. On the day of the audit there were 44 residents. This included 16 rest home residents (including one resident on transitional care contract) and 28 hospital residents (including two younger persons under a long-term support – chronic health condition contract and one resident under ACC). The service also has contracts for respite care, coordinated primary option contract and an Engage (transitional care) contract. There were no residents under these contracts on the day of audit. There are 30 dual-purpose beds and 15 rest home beds. On the day of audit, 10 rest home beds were assessed as</p>

<p>of consumers.</p>		<p>suitable for dual-purpose beds. This will give the service 40 dual-purpose beds and five rest home beds.</p> <p>Radius has an overarching three-year business strategic plan 2017 – 2020 which is reviewed regularly at regional meetings. Radius Hampton Court has a site-specific business plan that is reviewed three monthly to report on achievements towards meeting goals, including maintaining good occupancy through building DHB and community relationships, retention and education of RNs, falls reduction (link CI 1.2.3.6) and maintenance of internal audit programme.</p> <p>The mission statement, philosophy and Radius vision of EPEC (exceptional people, exceptional care) is being implemented at Hampton Court. The service is benchmarked against other Radius facilities and the facility manager provides the regional manager with a monthly report including financial, operational and clinical key performance indicators.</p> <p>The facility manager has been in the role for two years and was previously a clinical manager at another Radius facility for five years. She is supported by a clinical nurse manager, who has been in the role eight months and transferred from another Radius facility. A regional manager supports the facility manager in the management role. Another regional manager and a roving facility manager were present during the days of the audit.</p> <p>The facility manager (registered nurse) has maintained more than eight hours of professional development activities related to managing an aged care facility including attendance at the Radius annual conference, aged care forums, ARC meetings and leadership and business planning sessions.</p> <p>The clinical nurse leader completed induction to the facility and completed a role specific orientation and has maintained clinical management education.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the facility manager, the clinical nurse manager is in charge with support from the regional manager and roving facility manager.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>There is an organisational business plan that includes quality goals and risk management plans for Hampton Court. Quality and risk performance are reported across facility meetings and to the regional manager. The</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>facility manager advised that she is responsible for providing oversight of the quality programme. There are fortnightly “triangle of support” meetings with each head of department. There are monthly combined quality improvement/health and safety and infection control meetings where all quality data and indicators are discussed. Minutes of meetings and graphs of key performance indicators/trends are made available to all staff. Staff meetings are held two monthly and there are two monthly staff newsletters. Required actions and resolutions from facility meetings are documented.</p> <p>Annual resident satisfaction surveys are completed with results communicated to residents and staff. The overall satisfaction rate in 2018 demonstrated an increase in satisfaction from 2017. The 2019 survey is not due until October.</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. The support office reviews policies within the required timeframes in consultation with the facility managers and clinical coordinators. Staff are informed of policy reviews through meetings and time target. Clinical guidelines are in place to assist care staff.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. Data is collected in relation to a variety of quality activities including accidents and incidents, infections, internal audits, surveys, concerns/complaints. An internal audit schedule has been completed. Areas of non-compliance (below 95%) identified through quality activities are actioned for improvement. Re-audits are completed as required. Corrective actions are evaluated and signed off when completed.</p> <p>Health and safety policies are implemented, reviewed and monitored by the health and safety committee (which is combined with the quality improvement meeting). The health and safety committee are representative of all areas. The health and safety officer (interviewed) has completed health and safety courses level one and two and a refresher for update to the new legislation. New staff complete a health and safety orientation. A current hazard register is available to staff. All contractors complete an initial site induction.</p> <p>Falls prevention strategies are based on the individual resident’s risk and documented in care plans. The service has implemented these strategies to successfully reduce falls over the last year.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and</p>	<p>FA</p>	<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 (KPI). There is a discussion of incidents/accidents at the monthly health and safety/quality improvement, staff and clinical meetings. A review of fifteen incident/accident forms from May 2019 identified that forms are fully completed and include follow-up by a RN, however not all neurological observations were completed (link 1.3.6.1). Discussions with the facility manager and regional manager</p>

<p>reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been two section 31 notifications made since the last audit for an unstageable pressure injury (April 2019) and absconding (June 2019). Two norovirus outbreaks (July and October 2018) were also notified to the public health authorities.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Nine staff files reviewed (one clinical nurse manager, two RNs, three HCAs, one activities coordinator, one kitchen manager and one maintenance/health and safety officer) were reviewed. Staff files included a recruitment process with reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals. A register of RN staff and other health practitioner practising certificates is maintained. Registered nurses are supported to maintain their professional competency. The orientation programme provides new staff with relevant information for safe work practice.</p> <p>Staff are required to complete written core competencies during their induction. These competencies are repeated annually, including safe manual handling (taken by the physiotherapist), hoist, health and safety, hand hygiene, infection control questionnaire and restraint competency as applicable to their role. There is an implemented annual education and training plan that exceeds eight hours annually and covers all compulsory training. There is an attendance register for each training session and an individual staff member record of training. One of five RNs plus the facility manager and clinical nurse manager have completed their interRAI training. Registered nurses are supported to maintain their professional competency.</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>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Residents and family members interviewed reported there are sufficient staff numbers. There is a full-time facility manager and clinical nurse manager who work from Monday to Friday. There is one RN on each shift over 24 hours. The facility is divided into three wings: Kensington (12 beds – five rest home and seven dual-purpose), Mission (16 dual-purpose beds) and Garden (17 dual-purpose beds).</p> <p>Staffing is as follows: Kensington with four hospital and eight rest home residents – on morning shift there is one HCA on full shift and one HCA until 1.30 pm, on afternoons there is one HCA on full shift.</p> <p>Mission with eleven hospital and five rest home residents – on morning shift there is one HCA on full shift and one HCA until 1.30 pm, on afternoons there is one HCA on full shift and one HCA until 9.30 pm.</p> <p>Garden with eleven hospital and five rest home residents - on morning shift there is one HCA on full shift and one HAC until 1.30 pm, on afternoons there is one HCA on full shift and one HCA until 9.30.</p> <p>There is assistance from an HCA “floater from 7.00 am - 1.30 pm and an afternoon HCA “floater” 4.00 pm – 8.30 pm. These shifts can be extended to meet increased resident acuity/needs. There is also a support person</p>

		<p>from 0800 to 1600 daily who assists with bedmaking, meals, activities, fluids etc</p> <p>There are two HCAs on full night shift.</p> <p>There are designated staff for activities, food services, laundry and cleaning.</p> <p>Residents and relatives interviewed felt there was enough staff on duty. HCAs stated in interview there were sufficient staff to deliver cares.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files sampled were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office. Electronic records are password protected.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Communication with family is made.</p>

transfer from services.		
<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>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. All policies and procedures had been adhered to. There were no standing orders. There were no vaccines stored on site.</p> <p>The facility uses a paper-based and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent HCAs administer medications. All staff have up-to-date medication competencies and there has been medication education this year. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked daily. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on medication signing sheets. Fourteen medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use 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>	FA	<p>The service has a head cook who works Monday to Friday 8.00 am - 4.30 pm. There is a tea cook who works 4.00 pm – 7.30 pm and covers weekends. There are three kitchenhands who cover 6.30 am – 2.30 pm between them. All have food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served in one dining room from a bain marie and in the other dining room from a hot box. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the first day of audit, meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a whiteboard. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were satisfied with the meals.</p> <p>The food control plan was verified on 20 June 2019.</p>
<p>Standard 1.3.2: Declining Referral/Entry</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be</p>

<p>To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files reviewed indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all ARRC residents. Goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but not limited to) nutrition, pain, challenging behaviour and continence.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Electronic care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions documented support needs and provide detail to guide care. Care plans are updated for acute changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, wound care nurse and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Registered nurses stated that they notify family members about any changes in their relative's health status and family interviewed confirmed this. All care plans reviewed had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. Care staff interviewed stated that they found the care plans very useful and a guide for care needed.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>There are currently six wounds being treated (including the two pressure injuries). Wound assessment, wound management and evaluation forms are documented electronically, and documentation was all up to date.</p>

		<p>Wound monitoring occurs as planned.</p> <p>There is currently one stage two pressure injury and one unstageable pressure injury. Pressure injury prevention equipment is available and in use. HCAs document changes of position electronically. The unstageable pressure injury has been seen by the GP and the wound care nurse specialist. The wound care nurse specialist is referring the wound for surgical debridement. There are photos of the wound's progress and a section 31 has been completed.</p> <p>Electronic monitoring forms are in use as applicable such as weight, vital signs and wounds. Resident falls are reported electronically and written in the progress notes. Neurological observations are required for unwitnessed falls or falls where residents hit their heads, however these have not always been completed as per protocol.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is one activity coordinator who works 36 hours a week. She has an assistant who also works 36 hours a week. The activities coordinator has level 3 and is overseen by a Radius diversional therapist. On the days of audit residents were observed doing exercises, going on a van outing and being entertained by schoolchildren.</p> <p>There is a weekly programme in large print on noticeboards and some residents also have a copy in their rooms. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There is a monthly interdenominational church service and a weekly Roman Catholic communion.</p> <p>There are van outings twice weekly and these are very popular. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Father's Day, Anzac Day and Matariki are celebrated.</p> <p>There is pet therapy monthly and the hospital has a cat. There is a falls prevention programme and part of this includes a weekly walking group (link CI 1.2.3.6).</p> <p>There is community input from pre-schools and schools. Residents go out to the RSA for lunch monthly and there are organised outings to museums, art galleries etc.</p> <p>The three young people (ACC and long-term chronic health care) join in exercises and music as well as having one-on-one time. They are informed of activities and outings and choose to participate as desired.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held two monthly.</p>

		In 2016 the facility commenced a quality improvement initiative plan for exercises, and this has continued. There are 15 residents that regularly attend. This year they have added on a small group three days a week for high level care residents. The aim is to build confidence and reduce falls through increased participation in an exercise programme (link CI 1.2.3.6). The high level of care exercise group programme was designed in conjunction with the clinical team and the physiotherapist. Music therapy is incorporated into the programme. Free movement at an individual level is encouraged – this may be moving fingers or toes, nodding heads and arm exercises to help maintain strength. The pace is gentle and focused. The programme utilises equipment such as bean bags, balloons, balls and stretch bands.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Six care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. A care plan was in place for the transitional resident. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, HCAs, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, mental health services for older people and the wound care nurse specialist. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.
Standard 1.4.1: Management Of Waste And Hazardous Substances	FA	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. The facility has initiated a project to look for cost effective ways to

<p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>reduce the overall carbon footprint on waste management.</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>The building holds a current warrant of fitness which expires 1 July 2019 (renewal is underway). There is a maintenance man who works 25 hours a week. He is also responsible for the lawns and there is a contracted gardener. A contracted electrician and plumber are available when required.</p> <p>Ten rest home rooms were assessed as suitable for dual purpose level of care.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges, hallways and bedrooms are carpeted. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>Environmental improvements include, new carpet, drapes and improved lighting in all communal areas, new call bell system, upgrade of Kensington and Mission bathrooms, new van with mobility hoist and landscaping.</p> <p>Healthcare assistants interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene</p>	<p>FA</p>	<p>Nineteen rooms have ensuites. All other rooms have hand basins and six rooms have toilet ensuites. There are sufficient communal showers and toilets. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are privacy signs on all shower/toilet doors.</p>

requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. The 10 large rooms assessed for dual-purpose have sufficient space for the safe delivery of hospital level care residents with seven in the rest home wing (Kensington) for standing hoist only and the other three rooms in the hospital wing can accommodate the use of a full hoist. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. There is a hairdressing salon.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being</p>	FA	All laundry is done on site. There is a laundry worker responsible for all the laundry. The laundry is divided into a "dirty" and "clean" area. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away when not in use. All chemicals on the cleaner's trolley were labelled. There are two sluice rooms for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms and the laundry are kept closed when not in use.

provided.		
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an emergency health management plan in place to guide staff in managing emergencies and disasters. The service has a memorandum of understanding with the DHB for either party to provide support in the event of a civil defence emergency. Emergency procedures are included in the staff orientation programme and compulsory education programme. There is a first aid trained staff member on every shift. There is an approved fire evacuation plan dated 15 July 1999. Fire evacuation drills occur six monthly with the last evacuation drill occurring May 2019. The service has adequate civil defence supplies including alternative cooking facilities (BBQ), food and water (bottled and ceiling tanks) for 10 litres per person per day as per the MOH recommendations. The service has a back-up system for emergency lighting and hand bells should the call bell system fail. Civil defence kits in the facility are checked monthly. Call bells are in residents' rooms, ensuites, communal areas and communal toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. Call bells are checked six monthly.</p> <p>The service has a visitor's book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. There is underfloor heating as well as heat pumps. An air conditioning unit has been installed in the main lounge to improve the environment in summer months. Staff and residents interviewed stated that this is effective.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be</p>	FA	<p>Radius Hampton Court has implemented the Radius infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The clinical nurse manager (RN) is the designated infection control coordinator with a job description that outlines the responsibility of the role and reporting requirements. An HCA is designated to assist the infection control coordinator in the management of infection control across the service. The Radius infection control programme is reviewed annually at the regional meetings for clinical nurse managers.</p> <p>Visitors are asked not to visit if they are unwell. Hand sanitisers were appropriately placed throughout the facility. Residents and staff are offered the annual influenza vaccine.</p>

appropriate to the size and scope of the service.		
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	The infection control coordinator has completed infection control education included in the clinical nurse managers study days and an on-line course in June 2019. She has access to expertise within the DHB, gerontology clinical nurse specialist, public health, GPs and laboratory and is also supported by the facility manager and regional manager.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. The infection control policies link to other documentation, uses references where appropriate and are reviewed by Radius support office. Input is sought from infection control coordinators when reviewing policies.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant</p>	FA	The infection control coordinator ensures all new staff are orientated to infection control as part of the orientation programme and at least annually thereafter. Staff complete infection control competency questionnaires and hand hygiene audits. Topical toolbox talks are also provided.

<p>education on infection control to all service providers, support staff, and consumers.</p>		<p>Resident education is expected to occur as part of providing daily cares.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme. Infections by type are collated monthly and reported to the combined quality, health and safety and infection control meetings. Data is analysed for trends and corrective actions. Meeting minutes and graphs are displayed for staff reading. Infection control is an agenda item on all facility meetings. The service submits data monthly to Radius support office where benchmarking is completed.</p> <p>There have been two norovirus outbreaks (July and October 2019). Case logs and the notification to the DHB health protection officer were sighted. The service received an email commending the service on the prompt outbreak management plans put in place to minimise the effect on residents.</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>The service has documented systems in place to ensure the use of restraint is actively minimised. The clinical nurse manager is the restraint coordinator. At the time of the audit there were no residents using restraints and one hospital resident using an enabler (bedrail). A voluntary consent had been completed and an assessment identified risks with the use of the enabler. The care plan reviewed identified the use of an enabler and risks as per the assessment.</p> <p>Staff receive training around restraint minimisation and complete competency questionnaires. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Neurological observations are required for unwitnessed falls or falls where residents hit their heads, however these are not always completed as per protocol.	Three of four unwitnessed falls did not have neurological observations completed as per protocol.	<p>Ensure neurological observations are completed as per protocol for unwitnessed falls.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The service identified an opportunity to reduce falls due to an increase in falls to 15 in the month of April 2018. There were a number of initiatives implemented which have been successful in reducing falls over the past year, well below the Radius falls average.	An action plan was developed in consultation with the clinical team and regional manager which included; a) initial assessments for hospital and rest home residents by the physiotherapist and development and review of mobility plans by the physiotherapist and RNs, b) staff education around falls prevention strategies, c) safe manual handling sessions for all staff taken by the physiotherapist, d) review of all falls accident/incidents and post falls assessments including identification of contributing factors/corrective actions, e) monitoring, trending and analysing of accident/incident data to identify areas of improvement and increased resident participation in strength and balance classes and walking groups. Care staff interviewed were knowledgeable in falls prevention strategies. The facility manager participates in the fall's minimisation group at the DHB and promotes best practice for falls prevention at the facility. For the period April 2018 to April 2019 the Radius average for falls of facilities of a similar size was 17%. Radius Hampton Court falls average was 9%.
Criterion 1.4.1.1	CI	In September 2017 the facility recognised the large	1) In the kitchen area: food packaging is recycled, used vegetable oil is re-purposed as bio-oil, there is no grease trap used on site, menus and recipes are adhered to and menu

<p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.</p>		<p>amount of non-degradable waste that is produced in day-to-day practise within the facility. Staff started looking for cost effective ways to reduce the overall carbon footprint in waste management. The service has been successful in achieving its aim to reduce waste management costs by 10% over 24 months.</p>	<p>items are changed when residents show a dislike for them – this leads to reduced food wastage, food waste is put into the Insinkerator, pre-prepared vegetables are sourced to reduce peels/scraps, used milk containers are given to a local florist to display cut flowers.</p> <p>2) Clinical: all continence products in use are fully biodegradable, product packaging is mostly paper and cardboard – minimal plastic packaging is used, medication cups used are able to be washed in the dishwasher – no single use, there is an electronic documentation system in use to reduce printing and paper costs, robotic packs used for medications, bio-hazard material is disposed by a medical hazard company and not sent to landfill.</p> <p>3) Office, cleaning and laundry: small plastic bags and bin liners are being replaced by paper bags and biodegradable bags, cleaning products and laundry detergents are all biodegradable.</p> <p>General waste: all recyclable waste is recycled; green waste is collected separately.</p> <p>The facility celebrates the reduction in waste. If they had not changed practice, they would have had to double their current number of general waste bins. They currently have five recycle bins and ten general waste bins in use.</p>
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End of the report.