

Radius Residential Care Limited - Radius Hampton Court

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 BSI Group New Zealand Ltd, 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: 25 November 2021 End date: 26 November 2021

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

General overview of the audit

Radius 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 currently managed by a new facility manager who is supported by a roving facility manager/registered nurse. She is supported by a Radius regional manager and a clinical manager. Residents, relatives, and the GP interviewed spoke positively about the service provided at Hampton Court.

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

The service continues to make environmental improvements including purchasing of new bedroom furniture, furnishings, and kitchen equipment.

The shortfall identified at the previous audit related to neurological observations has been addressed, but a further shortfall has been identified around care plan interventions.

The service has been awarded a continuous improvement around falls reduction and nutrition provision.

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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There are effective communication processes at all levels of service delivery. Families are regularly updated of residents' condition including any acute changes or incidents.

Complaints processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing communication related to Radius Care Covid-19 prevention strategies.

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. A job-specific 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 medium or high risk and/or unattained and of low risk.</p>
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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 demonstrated 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 general practitioner.

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. Internal areas are appropriate for safe mobility of residents. External areas are safe and well maintained with shade and seating available. There is adequate equipment for the safe delivery of care.

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.

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking against other Radius Care facilities. There are organisational Covid-19 prevention strategies in place.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	0	1	0	0
Criteria	2	38	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 complaints process. Information about complaints is provided on admission. Management operates an open-door policy. Interview with four relatives and three residents (all rest home level) confirmed an understanding of the complaints process. There is an up-to-date online complaint register. There has been one complaint in 2019 (since the last audit), two internal complaints for 2020 and four for 2021 (including one to the Health and Disability Commission - HDC).</p> <p>One recent complaint lodged with HDC in July 2021 was resolved through the Health and Disability advocacy services. Another HDC complaint lodged in 2018 and commented on at the previous audit has now been resolved (March 2020) with findings related to clinical documentation, corrective actions had been implemented around staff education including RN assessment and critical thinking. All staff completed the related training.</p> <p>The facility manager and clinical manager share the management of complaints reporting process and outcomes. The regional manager is involved in high-risk complaints and investigation. All complaints were acknowledged within the required timeframe and letters of acknowledgement/investigation and resolution offered advocacy contact and details.</p>
Standard 1.1.9: Communication	FA	There is a policy to guide staff on the process around open disclosure and for residents who do not have any family to notify. The managers (roving facility manager, facility manager, clinical manager, and regional manager) and one

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>registered nurse (RN) interviewed, confirmed family are kept informed. Nine staff interviewed (four healthcare assistants [HCAs], one kitchen manager, one kitchen assistant, one maintenance person (health and safety representative), diversional therapist and one activities coordinator) were able to describe the communication processes and a and the facility strategy under the covid19 preparedness framework.</p> <p>Four relatives (three rest home and one hospital [LTS-CHC]) stated they are notified promptly of any incidents/accidents or any changes to the resident health status. There was documented evidence of family notification recorded on the significant events record in each file including accidents/incidents, infections, general practitioner visits (GP), behavioural changes and medication.</p> <p>Ten incident and accident forms reviewed across September and October 2021 evidenced that family are notified following adverse events.</p> <p>Resident/family meetings encourage open discussion around the services provided. Radius Hampton Court with support at organisational level, took a proactive approach undertaking a comprehensive internal communication plan which included posters, videos, and brochures with essential factual information for staff and residents to understand Covid-19 vaccination information.</p> <p>The family members interviewed spoke positively about the care provided and were well informed around Covid-19 strategies and felt supported. There is access to an interpreter service if required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Radius 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 22 rest home residents (including one resident on respite care) and 22 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 coordinated primary option contract and an Engage (transitional care) contract. There were no residents under these contracts on the day of audit.</p> <p>There are 40 dual-purpose beds and five rest home beds.</p> <p>Radius has an overarching three-year business strategic plan 2021 – 2023 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 and maintenance of internal audit programme.</p> <p>The mission statement, philosophy and vision is implemented and reflective in the business plan. 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 appointed to the role in the last two weeks and has extensive management experience in aged care. The facility manager is a registered nurse with a current annual practicing certificate and</p>

		<p>is supported by a Radius roving facility manager who assists with induction to the service. The facility manager is supported by a clinical manager, who has been in the role for two weeks and has been a registered nurse at the same facility for the last two years. A regional manager supports the facility manager in the management role. The roving facility manager is a registered nurse and also supports the clinical manager with her induction.</p> <p>The roving and new facility managers have maintained more than eight hours of professional development activities related to managing an aged care facility including attendance at Zoom aged care forums, ARC meetings and leadership and business planning sessions. There is a well-documented transition and induction plan for the two new managers into their roles.</p> <p>Both managers were in the process of completing role-specific induction to the facility and have access to the online platform to completed training (Triangle of support) related to management of an aged care facility. HealthCERT has been notified of the change in clinical and facility managers.</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>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 facility manager is responsible for providing oversight of the quality programme. There are fortnightly 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. 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 2020 demonstrated an increase in overall satisfaction from 2019. The regional manager interviewed confirmed an improvement was required to increase the satisfaction survey response rate. Corrective actions were implemented and the response rate of 33% in 2019 improved to 96% in 2020. The 2021 survey is not due until end of November 2021 and has been distributed as required.</p> <p>Data is collected on complaints, hazards, accidents, incidents, infection control and restraint/enabler use. Benchmarking with other Radius facilities occurs on data collected. Staff are informed of results and other quality information through several meetings and communication methods including message board and email.</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. The regional manager is involved in benchmarking the facility against other Radius care facilities. Areas of non-compliance (below 100%) identified through quality activities are actioned for improvement. Re-audits are completed as required. Corrective actions are evaluated and signed off when completed. Staff are informed of quality outcomes including corrective actions required at the staff and quality and</p>

		<p>health and safety meetings.</p> <p>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 related to smoking and vaping and work safe notifications. New staff complete a health and safety including emergency preparedness at orientation. A current hazard register is available to staff and has been reviewed in March 2021. There is an annual preventative maintenance plan available (sighted). 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 implements individual strategies to successfully reduce falls.</p> <p>The service has achieved a continuous improvement rating for the reduction of falls through optimisation of medication.</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 (KPI). There is a discussion of incidents/accidents at the monthly health and safety/quality improvement, staff, and clinical meetings.</p> <p>A review of ten incident/accident forms from across September and October 2021 identified that forms are fully completed and include follow-up by a RN, all neurological observations were completed for unwitnessed falls and any suspected head injuries. Discussions with the facility manager and regional manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>There have been four section 31 notifications made since the last audit for an unstageable pressure injury and three stage three pressure injuries. There were no outbreaks since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files reviewed (three RNs, two HCAs, and the clinical manager) were reviewed. Staff files included a recruitment process with reference checking, signed employment contracts and job descriptions, police checks, completed job specific 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>conducted in accordance with good employment practice and meet the requirements of legislation.</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. Four of six RNs plus the new facility manager and new clinical manager have completed their interRAI training. Registered nurses are supported to maintain their professional competency.</p> <p>Staff are encouraged to complete New Zealand Qualification Authority (NZQA) qualifications. There is a total of 26 HCAs. Currently there are eight who have achieved level 4, seven who have achieved level 3, and four achieved level 2, the others are working towards a qualification. Healthcare assistants have direct access to the Radius e-learning online platform to complete NZQA qualifications.</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 manager who work from Monday to Friday.</p> <p>A full time AM shift RN covers Monday - Sunday plus a part time RN is allocated on morning shifts on a Wednesday, Saturday, and Sunday.</p> <p>A full time RN covers PM shift Monday - Sunday with a second RN 1.30 pm-9.30 pm Monday - Sunday</p> <p>There is one registered nurse over the facility overnight.</p> <p>There is one roster (with a total of eight HCAs on am shift, five HCAs on pm shift and two HCAs on night) that work across the wings and assist each other where and when required.</p> <p>Staff are allocated to the following areas (1 and 2):</p> <p>Area 1: Staffing is as follows for a total of 21 residents (seven rest home residents and 14 hospital residents including one ACC and two LTS-CHC))</p> <p>AM: two HCA 7 am-3 pm, two HCAs 7am-1.30pm and one from 7am-11am (can be extended if needed)</p> <p>PM two HCA (3 pm-10 pm and 3 pm to midnight) and one HCA 4pm—9.30 pm</p> <p>NIGHT: one HCA 11pm-7am</p> <p>Area 2: Staffing is as follow for total of 23 residents (15 rest home including respite and eight hospital):</p> <p>AM: one HCA 7am-3pm, and one HCA until 1.30 pm, and one from 8 am-1.30 pm (supporting the DT with 1:1</p>

		<p>activity, bedmaking, meals)</p> <p>PM: one HCA on full shift(3am-11pm), one HCA until 10 pm and 5pm-10pm (floater)</p> <p>NIGHT: one HCA 11pm-7amThere is assistance from an HCA “floater from 7 am – 11mm and an afternoon HCA “floater” 5 pm – 10 pm. These shifts can be extended to meet increased resident acuity/needs.</p> <p>There are designated staff for activities, food services, laundry, and cleaning.</p> <p>HCAs stated in interview there were sufficient staff to deliver cares.</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>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 paper-based medication charts and a 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 and room temperatures are checked daily and are within range as per policy. Eye drops and ointments are dated once opened.</p> <p>Staff sign for the administration of medications on medication signing sheets. Ten medication charts were reviewed. Medications are reviewed at least three-monthly by the GP and pharmacist.</p> <p>There was current and recent photo identification and allergy status recorded. ‘As required’ medications had indications for use prescribed. Medication entries in the relevant registers had been completed as required by the relevant guidelines.</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</p>	FA	<p>The service has a kitchen manager who works Monday to Friday 8 am - 4.30 pm. There is a tea cook who works 4 pm – 7 pm and covers weekends. There are two kitchen assistants who cover 6.30 am – 3.30 pm between them. All have food safety certificates.</p> <p>The kitchen manager oversees the procurement of the food and management of the kitchen.</p> <p>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 and to rooms 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</p>

<p>component of service delivery.</p>		<p>implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily on an electronic application platform. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements, 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. There has been a marked improvement and increase in resident satisfaction with meals from the 2020 survey to current.</p> <p>The food control plan expires on 15 June 2022.</p> <p>The service has attained a continuous improvement rating by implementing initiatives to improve the meal service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</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. Not all care plans had detailed interventions documented to meet the needs of the residents. Care plans have been updated as residents' needs changed. Care staff interviewed stated that they found the care plans extremely 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 one stage three pressure injury). Wound assessment, wound management and evaluation forms are documented electronically, and documentation was all up to date. Wound monitoring and dressings occur as planned. There is evidence (photos) of wounds progressing towards healing.</p> <p>Pressure injury prevention equipment is available and in use. HCAs document changes of position electronically. The stage three pressure injury has been seen by the GP and the wound care nurse specialist. The wound care nurse specialist at the DHB was consulted to advice if imminent surgical debridement is required.</p> <p>Electronic monitoring forms are in use as applicable such as weight, pain, repositioning, food and fluid intake, 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. These have all been completed as per protocol. The shortfall identified at the previous audit remains as there continue to be shortfalls related to interventions.</p>
<p>Standard 1.3.7:</p>	<p>FA</p>	<p>There is one activity coordinator who works 8 am-4 pm Monday to Friday. She is supported by an HCA (support</p>

<p>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>person) who works 1.30 pm – 4 pm to provide 1:1 therapy for ten residents. The activities coordinator is working towards a diversional therapist qualification. On the days of audit residents were observed doing exercises, quiz, and balloon therapy. Activities are scheduled over seven days a week. There are plenty of activity resources available for any staff that need to support a resident or group of residents with activities.</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 exceedingly 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.</p> <p>There is community (when Covid restrictions permit) input from volunteers (when permitted). Residents go out on organised outings, picnics, lunches, and scenic drives.</p> <p>The two young people (ACC and long-term chronic health care) are assisted to join in activities. Their relatives are informed of activities.</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 where residents can give feedback on activities, meals, and other interests in an open forum. Residents interviewed stated they received regular updates regarding house matters including Covid-19 strategies.</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>Four 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 respite resident (link 1.3.6.1). Registered nurses' complete evaluations against the resident individual goal. 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.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness which expires 1 July 2022. There is a maintenance person who works 31 hours per week. He is also responsible for small maintenance projects and maintaining the garden. A contracted electrician and plumber are available when required.</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. There were two instances recorded where hot water temperatures were recorded at a specific tap at 50 degrees Celsius, the necessary corrective actions were implemented. There is a documented record of preventative and reactive maintenance.</p> <p>The communal lounges, hallways and bedrooms are carpeted. Carpets were commercially cleaned on the day of the audit. 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 level underfoot access to all communal areas.</p> <p>Environmental improvements include new bedroom furnishings and furniture, refresh of painting in bedrooms, new kitchen equipment includes double door chiller and combi oven.</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 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The 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 at all facility meetings. The service submits data monthly to Radius support office where benchmarking is completed.</p> <p>There is a documented process to clean reusable equipment including slings and eyewear. Staff were observed practicing effective handwashing techniques.</p> <p>There are requirements for all visitors, staff, and contractors to wear masks, contact trace, individual temperature recording and written declaration of vaccination status.</p>
<p>Standard 2.1.1:</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. The clinical</p>

<p>Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>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>
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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>	<p>PA</p> <p>Moderate</p>	<p>Five care plans were reviewed. Where an interRAI assessment is required, triggers, scores and outcomes form the basis of the long-term care plan. Interventions were documented to address risks; however, the interventions were not always documented to a detail that can sufficiently guide staff in the management of their cares. It is important to note that all supplementary documentation including worklogs, medication charts, monitoring documentation and progress notes evidenced residents receive the appropriate care and this finding relates to a documentation issue.</p> <p>Care staff interviewed were knowledgeable about the cares required for each resident and the clinical manager with support from the registered nurses ensured the care plans showing a deficit was corrected on the last day of the audit.</p> <p>The shortfall identified at the certification audit has been however there continue to be shortfalls around interventions. The risk rating has been raised from low to moderate.</p>	<p>(i) The initial care plan for the respite resident was signed off but incomplete.</p> <p>(ii) A resident (LTS-CHC) pain management, agitation, comfort cares and pressure relieving management has not been documented.</p> <p>(iii) A resident</p>	<p>(i)-(iii) Ensure interventions are documented to a detailed level to sufficiently guide staff in the management of the residents.</p> <p>90 days</p>

			(hospital) skin care plan did not reflect recent changes related to the current pressure injury management.	
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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
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Radius Hampton Court continues to work on improving reduction of falls and realise the value of interprofessional collaboration to improve medicine use and health outcomes for its residents.</p> <p>The resident needs, care goals, current level of functioning and preferences are ascertained when polypharmacy are reviewed.</p>	<p>The GP three monthly medication reviews include a multi-disciplinary approach to optimising medication and identify the risks and problems associated with medication overload and polypharmacy. Review of care delivery documentation including multidisciplinary meetings, progress notes, allied health notes and medication charts evidenced decision making is shared between the resident, EPOA, GP, pharmacist, and clinical team to discontinue prescribed medication where it no longer provides a benefit. It is difficult to ascertain the clinical outcomes, however the quality data at Radius Hampton Court evidenced that the falls YTD is lower than 2019 YTD and 2020 YTD. There were no fractures related to falls recorded for 2020-2021 YTD. The safe and effective use of medication minimise the risk of falling by decreasing factors that usually contributes to falls in the elderly (eg: low blood and confusion). The proposition made as a basis for reasoning is the optimisation of medication and quality of prescribing decrease risks associated with falls related to hypotensive episodes and decrease in cognitive function. The GP interviewed confirmed her commitment with prescriber-pharmacist medication reviews. The relative/residents survey of 2020 evidenced a 95% satisfaction in communication and care received.</p>

<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>CI</p>	<p>Radius Hampton Court completed a relative/resident survey in October 2019 with an overall satisfaction rate of 77% related to food services. Although there were no corrective actions required the kitchen manager (qualified chef) understands that the overall dining experience including the visual appearance of meals matters. Several initiatives were implemented to improve the food/meal service.</p>	<p>An action plan was developed in consultation with the clinical team and regional manager and include an improvement in the overall dining room experience, review of the menu and putting resident feedback and suggestions into the menu.</p> <p>Continuous feedback and suggestions were gathered to improve meal planning and considered medical needs, allergies and intolerances, dietary restrictions (e.g., vegetarian), eating and swallowing capabilities, cultural customs, religious food practices, dementia, personal likes and dislikes, medicines being taken and additional energy requirements for residents at risk of malnutrition.</p> <p>Bimonthly resident meetings and follow-up surveys provided the opportunity to give feedback on the meal service. Dining room tables are well presented with the menu readily available to residents on display on each table. The residents can experience smells from the well-presented kitchen. The residents and relatives interviewed confirmed the kitchen manager is accessible, open to suggestions and they enjoy the meals provided to them.</p> <p>The overall satisfaction in the dining experience has increased from April 2020 (83%) to October 2021 (95%). The overall satisfaction per domain was as follows: variety (85%), quality (96%), desserts (100%), temperature (87%), midday meal (87%), evening meal (93%), soups (96%), texture (96%) and availability of fluids (100%).</p> <p>There were no residents with unintentional weight loss.</p>
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End of the report.