# Radius Residential Care Limited - Radius Heatherlea Care Centre

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Radius Residential Care Limited

**Premises audited:** Radius Heatherlea Care Centre

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 27 January 2015 End date: 28 January 2015

**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:** 48

# 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 |
|  | 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

Heatherlea is part of the Radius Residential Care Group. Heatherlea provides cares for up to 54 residents requiring dementia and rest home level care.

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

The facility manager has been at the service for three years and was on leave during the audit. She is supported by a clinical nurse leader and the Radius regional manager.

Five of the seven previous shortfalls have been addressed. These are around open disclosure, trend analysis, incident management, dementia specific training for staff and general practitioner initial reviews. Registered nurses follow up and medication administration continues to require improvement. This audit identified improvements required around aspects of medication management.

## Consumer rights

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| 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. |

There is an open disclosure and interpreters policy that staff understand. There are effective systems which are implemented to ensure appropriate communication with residents and families. There is a complaints policy supporting practice and an up to date register. Staff interviews confirmed an understanding of the complaints process.

## Organisational management

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| 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. |

There are organisational wide processes to monitor performance. There is a quality system that is being implemented in line with the quality plan. Staff and quality meetings are used to monitor quality activities such as audit, complaints, health and safety, infection control and restraint. There is an adverse event reporting system implemented at and monthly data collection monitors predetermined indicators. There are implemented human resource processes. There is an annual education programme and records of attendance are maintained. There is a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty match needs of different shifts.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The residents` needs, outcomes and/or goals are identified in the assessments and care plans are reviewed six monthly or more often as required. There is an implemented medication management system. Three monthly medication reviews are being completed by the general practitioners.

Food services are managed effectively. Meals are prepared on site. Nutritional guidelines and advice is available which is appropriate for this service setting. The menu plans have been reviewed by a dietitian and are suitable for the elderly residents.

An activities programme is provided and enjoyed by the residents in both the rest home and the dementia unit. Participation is encouraged but is voluntary. Community outings are arranged and entertainers are invited to participate in the programme.

## Safe and appropriate environment

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| 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. |

There is a current building warrant of fitness.

## Restraint minimisation and safe practice

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| 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. |

There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were no residents requiring restraint and no residents with identified enablers.

## Infection prevention and control

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| 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. |

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

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 14 | 0 | 0 | 2 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 0 | 2 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Residents and relatives were familiar with the complaints procedure and state all concerns /complaints are addressed.  The complaints log/register includes date of incident, complainant, summary of complaint, signature off as complete. There have been seven complaints in 2014. All have documentation of full investigation and resolution including communication with complainants is documented for all complaints.  D13.3h. A complaints procedure is provided to residents within the information pack at entry. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure policy. There are two monthly resident/relative meetings facilitated by the activities staff allowing residents/relatives to raise issues. Six relatives (three rest home and three from the dementia unit) and six residents (from the rest home) interviewed stated they were welcomed on entry and were given time and explanation about services and procedures.  Twelve incident reports reviewed all recorded family notification. The family members interviewed confirmed they are notified of any changes in their family member's health status. This is an improvement from the previous audit.  D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The facility has an interpreter policy to guide staff in accessing interpreter services. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Heatherlea is part of the Radius Residential Care Group. The service provides care for up to 54 residents requiring dementia and rest home level care. On the day of the audit there were 30 residents receiving rest home level care and 18 receiving dementia level care.  A three year business/quality/risk management plan 2014/2017 is reported against monthly at Heatherlea.  The facility manager has been in the role for three years and was on leave during the audit. The clinical nurse leader has been in the role since August 2014 and was previously working for three years as an RN in another Radius facility. The facility manager reports monthly to the regional manager on a range of operational matters in relation to Heatherlea including strategic and operational issues, incidents and accidents, complaints, health and safety.  The organisation provides annual conferences for their managers and annual regional conferences. ARC,D17.3di (rest home). The manager has maintained at least eight hours annually of professional development activities related to management of a rest home and dementia unit. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality system continues to be implemented at Heatherlea. Interviews with healthcare assistants confirmed that quality data is discussed at monthly staff meetings. There is also a monthly quality improvement meeting where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff. This is an improvement from the previous audit.  There are policies and procedures appropriate for service delivery. Policy manuals are reviewed two yearly. New/updated policies are sent from head office.  Radius benchmarks its own facilities against predetermined indicators that are reported monthly from facilities. The service collects internal monitoring data (internal audits) with the audit schedule being implemented at Heatherlea by the facility manager. Quality improvement data such as incidents /accidents, hazards, internal audit, infections are collected and analysed/evaluated at the quality meeting. Corrective action plans are developed for incident reports and all audits where there has been less than 95% conformity.  D19.3 There is implemented risk management, and health and safety policies and procedures in place including accident and hazard management.  D19.2g: Falls prevention strategies such as aggregating data monthly that includes considering time of occurrence. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | D19.3b; There is an accident/incident reporting policy/procedure. There is indicator month by month data collection including (but not limited to): falls (no injury, soft tissue, and fractures), skin tears, and medication and pressure areas. Monthly aggregation of data is undertaken and outcomes are discussed at all meetings - management, quality improvement and staff meetings.  Twelve incident forms sampled evidence detailed investigations and corrective action plans following incidents. Incident forms sampled where there has been a head injury have been followed up with neuro –obs. The incidents had been written up in the progress notes and all forms had been reviewed by the clinical nurse leader. This is an improvement from the previous audit.  D19.3c Discussions with the service (regional manager and facility manager) confirms an awareness of the requirement to notify relevant authorities (DHB) in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Recruitment, selection and appointment of staff policy is in place. Six staff files were reviewed and performance appraisals were current. Current practicing certificates are kept on file.  Heatherlea has an orientation programme that is specific to worker type. In staff files reviewed there was a record that an orientation had been completed.  E4.5d: The orientation programme is relevant to the dementia unit.  The service has an internal training programme directed by head office. The training programme has exceeded eight hours in 2014. Challenging behaviour and dementia are part of the training programme.  E4.5f: There are 23 caregivers who work in the dementia unit. Eighteen have completed the required dementia standards and the five who have worked at Heatherlea for less than 12 months have commenced their training.  E4.5e: The service does not use agency staff. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Acuity and clinical staffing ratio policy in place that includes a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty to match needs of different shifts. The facility manager works full time. The clinical nurse leader has been at this facility for five months and works full time.  Staff turnover is low. The three healthcare assistants and registered nurse interviewed stated that there is adequate staffing to manage their workload on any shift. There is a registered nurse on duty 24 hours per day in addition to the facility manager.  Six residents and six families interviewed confirm that there are sufficient staff on site. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Medications are checked against the doctor's medication profile on arrival from the pharmacy by an RN (the clinical nurse leader). Any mistakes by the pharmacy are regarded as an incident.  Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. Resident medication charts are identified with demographic details and photographs. The fridge that medications are kept in has a weekly temperature check. All 10 medication charts had allergies (or nil known), documented. All medications are stored appropriately.  There is currently one resident who self-administers medication and this resident has a current competency assessment.  D16.5.e.i.2: Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. Improvements are required around prescribing of as required medications and administration of non-packaged medications. The administration issue is a previous audit shortfall that has not yet been addressed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The service has a large workable kitchen. There is a rotating four weekly menu in place that was designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed.  Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented.  The residents and family members interviewed spoke highly about meals provided and they all stated that they were asked by staff about their food preferences.  The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires. All food is stored and handled safely. The kitchen is clean.  D19.2: Kitchen staff have been trained in safe food handling.  E3.3f: There is evidence that there are additional nutritious snacks available over 24 hours. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management plans are utilised as required. Short term care plans are routinely used for acute changes in health status. The GP interviewed stated the facility applied changes of care advice immediately and was highly complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission and resident’s primary care is provided by the residents own GP.  D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.  Specialist continence advice is available as needed and this could described.  Wound assessment and wound management plans are in place for three residents with wounds. There is evidence in one file sampled of wound specialist referrals. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The diversional therapist employed by the service works 35 hours over five days and an activities assistant works 30 hours per week. All recreation/activities assessments and reviews were up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge and in the dementia unit lounge. Residents have a comprehensive assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family.  Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life.  All residents and family members interviewed stated that activities are appropriate and varied.  D16.5d: Five resident files reviewed identified that the individual activity plan is reviewed at the time of the care plan review. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans in files sampled were developed by the clinical nurse leader (a registered nurse) within three weeks of admission and evaluated at least six monthly or if there is a change in health status. There is a three monthly review by the GP. Overall, changes in health status are documented and followed up (link 1.3.3.1). GP's review residents medication at least three monthly or when requested if issues arise or health status changes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a current building warrant of fitness. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory and skin. This data is reported to the facility meetings. Monthly data was seen in staff areas. The service submits data monthly to Radius head office where benchmarking is completed. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked. There is a regional restraint group at the organisational level and a restraint group at the facility where restraint is reviewed.  There are currently no residents with enablers or restraints. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Doctors are responsible for prescribing and all ten medication charts sampled have been reviewed at least three monthly by the GP. Seven of ten charts document the indication for use of prescribed as required medication. | (i) Three of ten medication charts sampled have regular medications that have not been signed as administered. (ii) Three of ten medication charts sampled do not document an indication for use for ‘as required’ (PRN) medication. | (i) Ensure medications are administered as prescribed. (ii) Ensure an indication for use is documented for ‘as required’ medication (PRN).  90 days |
| Criterion 1.3.3.1  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function. | PA Moderate | The registered nurse has documented a review in the progress notes at least between each seven and twelve days in the resident files sampled. The duty leader (a senior healthcare assistant) and the clinical nurse leader report that duty leaders have a book in which they document issues requiring review by the clinical nurse leader. | In one file sampled (a rest home resident) the duty nurse leader (a senior healthcare assistant) had documented a change in resident condition but the resident was not reviewed by the clinical nurse leader (the registered nurse). | Ensure that the clinical nurse leader is alerted when residents are unwell and that the clinical nurse leader reviews all residents with a change in health status and documents this.  60 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.