



Final Inspection Report

Radius Residential Care Limited - Althorp

31 October 2019

HealthCERT
Quality Assurance and Safety
Ministry of Health

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1. Provider Details

Certificate:	Radius Residential Care Limited - Althorp
Premises:	Althorp
Premises Address:	9 Grantston Drive, Pyes Pa, Tauranga
Contact Person:	Hannah Honey
Internal Ref:	PRMS_Audit_000016966001
Inspection Date:	31 October 2019

2. Executive Summary

Summary of findings:

The Ministry of Health (the Ministry) received information which alleged Radius Residential Care Limited could be in breach of its obligations as a certified provider under the Health and Disability Services (Safety) Act 2001 (the Act) to provide services at Radius Althorp. The concerns related to the standard of care delivered to residents in the psychogeriatric units, the competency of Registered Nurses, staffing levels including skills mix, incident reporting, and systemic issues across the quality and risk system.

This inspection was not linked to a complaint but did relate to agreed actions following a meeting between HealthCERT, Bay of Plenty District Health Board (DHB) and Radius Residential Care Limited on 5 June 2019, the outcome of which was that Radius Althorp were to meet the following:

- Radius Althorp and the DHB will work together and agree on strategies to support improved clinical and facility leadership.
- Radius Althorp will appoint an external person to review the competency, skills, behaviour and management of staff.
- Radius Althorp will confirm the staffing and skill mix of the dementia and psychogeriatric services.
- Radius will meet with families who have raised serious concerns about the standard of care.

The inspection was completed on 31 October 2019 at the Tauranga premise (Grantston Drive, Pyes Pa). The inspection was completed by the Ministry in accordance with sections 40, 41, and 43 of the Act. Two clinical nurse specialists from the Mental Health of Older Persons Team from the Bay of Plenty DHB were also on the inspection team.

The focus of the inspection was to consider and determine that clinical care was being provided to the required standard. The onsite inspection included review of resident files, and staff, clinical and relative interviews. Telephone interviews with relatives involved with Radius Althorp were completed post inspection.

Outcome:

Based on the evidence, Radius Residential Care Limited – Althorp did not fully comply with 15 of the Health and Disability Services Standards (NZS 8134:2008). The partially attained standards related to: consumer rights, organisational management and human resource management, service provider availability, service provision, restraint provision and process, and facility specifications. Three of the partially attained standards are of high risk.

Ongoing monitoring will be undertaken by Bay of Plenty DHB.

Corrective Actions Required

Radius Residential Care Limited is required to implement the following corrective actions

- A written progress reports that outlines all actions undertaken by the provider in relation to the corrective measures required against Health and Disability Services Standard 2.2 (as approved under Section 13 of the Act) must be submitted to HealthCERT by 13 December 2019. HealthCERT will notify the Director-General of Health of progress, if any, and if required in accordance with the Ministry of Health's requirements for the processing of progress reports.
- A written progress reports that outlines all actions undertaken by the provider in relation to the corrective measures required against Health and Disability Services Standard 1.2.2, 1.2.8, 1.3.9, 1.3.13 (as approved under Section 13 of the Act) must be submitted to HealthCERT by 13 January 2020. HealthCERT will notify the Director-General of Health of progress, if any, and if required in accordance with the Ministry of Health's requirements for the processing of progress reports.
- A written progress reports that outlines all actions undertaken by the provider in relation to the corrective measures required against Health and Disability Services Standard 1.2.3, 1.2.4, 1.2.7, 1.3.4, 1.3.5, 1.4.2 (as approved under Section 13 of the Act) must be submitted to HealthCERT by 13 February 2020. HealthCERT will notify the Director-General of Health of progress, if any, and if required in accordance with the Ministry of Health's requirements for the processing of progress reports.
- A written progress reports that outlines all actions undertaken by the provider in relation to the corrective measures required against Health and Disability Services Standard 1.1.10, 1.3.6, 1.3.7, 1.3.8 (as approved under Section 13 of the Act) must be submitted to HealthCERT by 13 March 2020. HealthCERT will notify the Director-General of Health of progress, if any, and if required in accordance with the Ministry of Health's requirements for the processing of progress reports.

Additional conditions to be placed on the Certification Schedule

Pursuant to section 28 of the Health and Disability Services (Safety) Act, the Director-General of Health may attach any condition the Director-General thinks necessary or desirable to help achieve the purpose of this Act.

3. Background

Law:

Providers of health care services must be certified by the Director-General of Health (Sections 9(a) and 26 of the Act) and must comply with all relevant health and disability service standards (Section 9(b)).

The relevant service standards are approved under the Health and Disability Services (Safety) Notice 2008. The standard approved is the Health and Disability Services Standards NZS 8134:2008.

Facts:

- a) Consumer Rights

Although residents in the psychogeriatric units had Enduring Power Of Attorney (EPOA) documents in their files, there was no documentation within the files to show that these had been activated.

b) Organisational Management

The requirements set by the Ministry of Health in June 2019 for Radius Althorp to meet were:

- 1) Radius Althorp and the DHB will work together and agree on strategies to support improved clinical and facility leadership.
- 2) Radius Althorp will appoint an external person to review the competency, skills, behaviour and management of staff.
- 3) Radius Althorp will confirm the staffing and skill mix of the dementia and psychogeriatric services.
- 4) Radius Althorp will meet with families who have raised serious concerns about the standard of care.

All except 4) of the above requirements have partially been met. The DHB Mental Health of Older Persons (MHOP) team has been continually providing clinical oversight over months for this facility, without leadership knowledge of the psychogeriatric service, and the continual change in staff, they have not been able to embed changes in service and at times their advice has not been followed regarding care for the residents. Radius Althorp appointed a senior manager from the Radius Group to be the “external” review person, this was not the intent of the requirement. Over the last six months the service has had a continuing change in management, which still is evolving.

c) Human Resource Management

Less than half the staff in the secure dementia and psychogeriatric units have completed the required New Zealand Quality Authority (NZQA) required units. Some are working towards these.

d) Service Provider Availability

Management has recently reviewed rosters and staffing on night shifts has been increased to two Health Care Assistants (HCA) in each unit. Interviews and observation of the roster showed that gaps in service are being filled, and extensive recruitment is underway. Weekend staff shortages are most often occurring, and HCAs work extra and double shifts to help fill the gaps. Often staff gaps are filled by newly orientated HCAs or HCAs from the hospital wings who are unfamiliar with the needs of psychogeriatric residents.

e) Service Provision Requirements

Assessment has little personalised data noted or indicators of distress, no notation of what causes anxiety or upset and what minimises, what makes happy etc. or how to intervene. Care plans were missing information from residents/whanau/EPOA (person specific). Goals and preferences are generic. Strategies for management are limited and do not reflect the Mental Health of Older Persons Team recommendations. There is a new process which has just commenced whereby personal memory boxes for dementia and psychogeriatric unit residents can be used by staff for distraction for the individual resident. These boxes are stored in the resident's room, however due to staff levels those that are in place are not utilised well.

Evaluation of original care plans are either not completed or not followed up. Where there is a change in the level of care required for a resident, referral to a service to meet needs is not always activated. Special nutritional needs are not always documented or followed to meet the residents' needs.

f) **Restraint Approval and Process**

All egress for residents in the psychogeriatric units into the outside secure garden areas were locked throughout the day. Management were unaware of this being environmental restraint within a secure unit.

g) **Observations**

The following are additional observations:

Facility Specifications.

Routine and as needed cleaning had not been carried out for chattels. All rooms containing Hazardous Chemicals were not securely locked. Corridors need to be kept unobstructed and safe for residents, staff and visitors. There was not always adequate room between seating to allow for personal space for residents who may be agitated and disturbed by such closeness.

4. Inspection Team

The inspection was undertaken by Ann Marie Bailey Senior Advisor, HealthCERT, Kerry Capelin, CNS, Bay of Plenty DHB, and Lisa Rogers Owen, RN Bay of Plenty DHB under the delegated authority of the Director-General of Health.

5. Inspection Methodology

The inspection was conducted to investigate the information made to the Ministry of Health that may have arisen from system failures and non-compliance against the Health and Disability Services Standards. Findings are according to the Health and Disability Services Standards NZS8134:2008.

The inspection was conducted using the following methods:

- Interview with Managers
- Individual staff interviews
- Relative/ Resident interviews
- Observation: During facility tours and casual observation of the facility
- Observation: Residents and Staff
- Document and policy review
- Clinical Notes review: A sample of residents' notes from the facility was audited.

6. Inspection Limitations

The scope of the inspection was limited to the issues raised in the information received.

7. Entry Meeting

On arrival at the premises, Ann Marie Bailey, Senior Advisor, HealthCERT, Kerry Capelin, CNS, Bay of Plenty DHB, and Lisa Rogers Owen, RN Bay of Plenty DHB, met with the Facility Manager.

The purpose of the visit was explained, and a letter addressed to Ms Heather Honey (the provider's nominated contact person) outlining the reason for the inspection and the authorisation to undertake the unannounced visit was given to the Facility Manager. A copy of the Director-General of Health's delegation was shown to the Facility Manager and it was explained how the inspection would be undertaken.

8. Inspection Findings

Findings have been reported against the following standards:

- Health and Disability Services Standards NZS 8134.1:2008
- Restraint Minimisation and Safe Practice NZS 8134.2:2008

Code	Finding	Corrective Action
HDS(C)S.2008:1.1.10	No activation of EPOAs in notes although one resident in process of PPPR through court process.	Ensure all EPOA activations occur for residents within the psychogeriatric units and that they are clearly documented.
HDS(C)S.2008:1.2.2	<p>Over the last six months the service has had a continuing change in management, which still is evolving. The service environment is providing a large component of psychogeriatric service (43%) alongside a smaller component of dementia service (14%), 57% of the total services. Within the senior and middle management teams there is no clinical expertise within psychogeriatric services. During this period of management there has been a high turnover of HCAs and Registered Nurses.</p> <p>The requirements set by the Ministry of Health in June 2019 of:</p> <ul style="list-style-type: none">• Radius Althorp and the DHB will work together and agree on strategies to support improved clinical and facility leadership.• Radius Althorp will appoint an external person to review the competency, skills, behavior and management of staff. <p>Have been partially met. The DHB Mental</p>	That immediate steps be taken to ensure that suitably skilled and clinically relevant staff are appointed at management level.

	<p>Health of Older Persons (MHOP) team has been continually providing clinical oversight over months for this facility, without leadership knowledge of the psychogeriatric service, and the continual change in staff, they have not been able to embed changes in service and at times their advice has not been followed regarding care for the residents. Radius Althorp appointed a senior manager from the Radius Group to be the “external” review person, this was not the intent of the requirement. This manager has completed a full report into a serious Health and Disability Commission (HDC) complaint and has made some improvements during their tenure, especially around a third requirement of improving communication with and meeting with families who have raised serious concerns about the standard of care. Families still report little change in the standard of care, and this is noted within findings in Continuity of Care.</p>	
HDS(C)S.2008:1.2.3	<p>There is a quality and risk program which the Acting Facility Manager is responsible for. Quality and risk performance is reported across facility meetings and to the Regional Manager. Data is gathered and analysed, but quality improvements are not documented at meetings for staff to implement. No evaluation of any changes, if made are reported back to staff meetings.</p>	<p>Ensure that quality improvement principles are followed through for quality and risk issues.</p>
HDS(C)S.2008:1.2.4	<p>Incident accident forms are collated but there is no follow through with outcomes or minimisation of recurring risk and quality improvement. Resident files and family both indicated incident and accidents are not always reported to family/whanau.</p>	<p>Ensure that all incident accidents are notified to family/whanau of choice and that outcomes or minimisation of recurring risk and quality improvements are carried out, documented and evaluated, and where necessary care plans are updated.</p>
HDS(C)S.2008:1.2.7	<p>Training has been provided for staff as a part of the annual training plan. This has not been specific for those working within the psychogeriatric units. Any training that has occurred has not involved expertise in this field. Less than half the staff in the secure dementia and psychogeriatric units have</p>	<p>Ensure that all staff are familiar with the specific needs for caring for residents within a psychogeriatric secure service and</p>

	completed the required New Zealand Quality Authority (NZQA) required units. Some are working towards these.	are aware of the difference between dementia care and psychogeriatric care.
HDS(C)S.2008:1.2.8	<p>Management has recently reviewed rosters, and staffing on night shifts has been increased to two Health Care Assistants (HCA) in each unit. Interviews and observation of the roster showed that gaps in service are being filled, and extensive recruitment is underway. Weekend staff shortages are most often occurring, and HCAs work extra and double shifts to help fill the gaps. A staff meeting requested that staff not exceed 90 hours per fortnight. Often staff gaps are filled by newly orientated HCAs or HCAs from the hospital wings who are unfamiliar with the needs of psychogeriatric residents.</p> <p>The Aged Related Hospital Specialised Services (ARHSS) Agreement also takes into consideration (D17.3(a)) the layout of the unit. This aspect of the agreement is not met. The units have a central quad area containing a large waterfall with plants enclosed in glass, taking up a great deal of space and preventing full view of corridors etc. by staff in the nurse's station. Lounges are small and chairs close to each other with little personal space between residents. Corridors lead off from the central quad area and cannot be easily viewed by staff. The external secure garden areas are also not able to be fully viewed by staff. Staff manage Activity for Daily Living (ADLs) for residents but do not have time to carry out activities or one on one activities.</p> <p>The units are staffed with two full time HCA plus an HCA from 7am to 1pm for the morning shift. After 11am (due to lunch break cover and need to write up progress notes on the computerised system) there are only two HCA per unit so one HCA needs to stay close to the lounge to monitor resident behavior. Afternoon and night shifts are staffed with two full time HCA. There is a shared RN across two units.</p>	Ensure that there are adequate staffing levels within the units with the required skill mix.
HDS(C)S.2008:1.3.13	One resident was at risk of malnutrition, but there were no special dietary requirements or regular snacks being provided. Another resident wanders away from the meal table, there were no strategies for having a meal at another time or another room for quietness or that they were offered frequent snacks.	Ensure that residents who have special nutritional needs have these clearly documented and that their needs are met.

	<p>Another resident has a swallowing/choking risk, but there was no documentation to alert staff to ensure that the food served was cut up into small amounts. If the resident is sat with other residents at a table, they will gulp their food and then commence to eat from other plates causing disruption. No minimisation of risk of a separate table in a quiet space was documented.</p>	
HDS(C)S.2008:1.3.4	<p>Assessment is all tick box with a summary score, no indicators for preferences in regard to nutrition or resident history/generalised strategies. Poor information gathered about the “person” as opposed to tasks. Poor or little communication with EPOA or family for knowledge of the person. Unrealistic goals set with no personalised data noted or indicators of distress, no notation of what causes anxiety or upset what minimises, what makes happy etc. or how to intervene when aggressive. The service has recently developed flip charts for each resident, due to the computer-based information being slow to access, when knowledge for de-escalation is required. This does not meet the requirement of an integrated care plan, and the flip charts contain multiple information and segments which could be confusing to staff with English as a second language. Language in care plan goals is suggestive of “doing to” rather than doing with or maintaining skills and abilities.</p>	<p>Ensure that assessments are fully comprehensive for the service provided, psychogeriatric specific, and care plans are integrated and easily accessible.</p>
HDS(C)S.2008:1.3.5	<p>Care plans were missing information from residents/whanau/EPOA (person specific). Fall risk highlighted but no follow up re how this affected by agitation, sight, memory etc. General statements like “to be free from risk”, “diet sufficient for resident” and “unusual behavior and to provide intervention” and “some resistance to toileting” but no details specific for the resident with strategies for staff to use. Goals and preferences are generic. “Monitor confronting presentations” but no specific descriptions of what these are and how staff should intervene. Under risk of absconding one resident had “Nil” written whilst verbalising a wish to go home. No regular dialogue with residents to check on emotional wellbeing. Files showed no evidence that basic daily observations are being translated into care plans, i.e. one resident had “bowels not opened for seven days, given laxative with effect”. This was not put into the care plan or management plan for the future. There is potential that this raises discomfort and contributes to</p>	<p>Ensure all care plans are current and promote continuity of service delivery.</p>

	<p>aggression. Recent fall but no triggers, hearing loss but no communication needs, no continence needs noted, no notation of what causes anxiety or upset, what minimises, what makes happy etc. or how to intervene when aggressive. One plan identifies need for support from spiritual perspective, but this did not translate into the care plan strategy. In one resident's file, comments show lack of staff understanding and ability to manage escalating behaviors. On three occasions noted "No triggers" however it had been documented the resident appeared frustrated and wanted to call police. Known behaviors were not addressed due to this lack of understanding.</p> <p>No focus on mental and emotional wellbeing, list of incidents focused on receiving cares with no specific need to identify potential cause of agitation and minimisation of this. Behavior seen as attributed solely to the resident with no consideration of any external focus that may impact on the resident. PRN use of medication noted for agitation.</p> <p>Strategies for management are "offer food/ fluid, reassurance and reorientation" these are limited and do not reflect the MHOP Team recommendations, which were removing others from personal space, quiet environment and knowledge of intrusive behaviors not being tolerated. In this case the care plan had not been updated since July 2019, so staff were not alerted to de-escalation strategies. No short-term care plans or review in response to recent changes in mobility or in relation to change in medications.</p> <p>Where staff had been assisted to write plans by the MHOP Team care plans were more detailed.</p>	
HDS(C)S.2008:1.3.6	Care plans did not always reflect the MHOP Team recommendations regarding interventions and meeting the consumer's needs. Staff are dependent on documented level of need to give information to clinicians, this can be hit or miss history from RNs, especially as there is a constant roll over of staff in the units, who are task orientated.	Ensure that interventions are consistent with the needs of the consumer, and that concerns for clinical review are clearly documented.
HDS(C)S.2008:1.3.7	There are four activities staff employed across the facility (two for the hospital / rest home wings i.e. one for each wing and two for the dementia/psychogeriatric wings, i.e. one for two wings each). Their hours of work	Ensure that activities programs are meaningful to individual consumers and that

	<p>are Monday to Friday from 9.30am to 4pm (from 3pm they are writing up reports). There is no late afternoon staff or weekend staff. There is time set aside for one hour per week for all activities staff to meet and plan work this includes planning for facility wide entertainment. The activities staff do not have access to occupational therapy mentorship or any links to other activities/ diversional therapist group locally to extend their knowledge and work processes. Their programs are mainly group activities apart from the hospital level of care where more one on one activity occurs. Generic plan, not specific for interests and abilities of residents, activities staff have little flexibility to deviate, and HCAs seem unsure as to what individual activities they can do, little evidence of one to one activity outside of family engagement. Relatives and staff have concerns regarding the “sundowning period” in the late afternoon and at weekends when HCAs are busy and have no time to carry out activities (two HCA per unit). Residents left to themselves most of the time, staff monitor but are not interacting. Magazines and TV volume up loud (whilst residents sat facing away from it) are used.</p> <p>There is a new process which has just commenced whereby they are setting up personal memory boxes for dementia and psychogeriatric unit residents (they rely on family to help fill these individual knowledge gaps for a resident), to be used by staff for distraction for the individual resident. These boxes are stored in the resident’s room, however due to staff levels those that are in place are not utilised well.</p>	<p>staff have access to training and mentorship.</p>
HDS(C)S.2008:1.3.8	<p>Evaluation of original care plans are either not completed or partially completed. In files there was discussion of therapeutic regime to control pain but did not describe what this might be. One file showed likelihood of pain but addressed it was as not having pain and not followed up.</p>	<p>Ensure that there are written care plan evaluations documented</p>
HDS(C)S.2008:1.3.9	<p>Four residents in the psychogeriatric units were noted as being in need of reassessment for non-secure hospital level care.</p>	<p>Ensure that referral to services are facilitated by assessment of their current needs.</p>
HDS(C)S.2008:1.4.2	<p>The hospital wings were observed to be dirty, with stained carpet in corridors and vinyl lifting (bubbling) in rooms. Use of roll out</p>	<p>Ensure that routine and as needed cleaning is carried</p>

	<p>mattresses (5cm thickness and dirty and stained) on floors, no enablers used (bed rails) beds were low-low and lowered. No anti-roll out mattresses on beds as prevention or sensor matts / bed edge sensors in use. Roll out mattresses were stored in corridors during the day, easily knocked down to form a trip hazard. Chairs stored in corridors were also dirty and stained. Sluice room doors were found, one with no lock and one wedged open with a towel by staff, all containing Hazardous Chemicals.</p> <p>The psychogeriatric units all had central quad areas which contained a glass enclosed large waterfall with plants. These take up a great deal of space and prevent full view of corridors etc by staff from the nurse's station. The main lounges are small, and chairs are close to each other with little personal space between residents. The quad area in the dementia unit has been removed and this allows for more freedom of movement for the residents, a larger seating area and good observation from the nurse's station.</p>	<p>out, all rooms all containing Hazardous Chemicals are securely locked and bubbling vinyl flooring is replaced. Corridors are kept clear of hazards and safe for residents, staff and visitors. Ensure that there is adequate room between seating to allow for personal space for residents who may be agitated and disturbed by such closeness.</p>
HDS(RMSP)S.2008:2.2.1	<p>All egress for residents in the psychogeriatric units into the outside secure garden areas were locked throughout the day. One end of corridor egress had a plaster tape cross on the top glass panel, one door had a handle that was unstable and the whole unit moved within the door frame, a ranch slider from a lounge was off track due to it trying to be forced open (bolt lock at top). When asked, management stated the DHB had requested doors to be locked. DHB response this was that post an adverse event where a resident had not been missed at night and had fallen outside, it was requested that doors be locked at night. Staff felt it was easier to monitor residents whilst they were indoors – too few staff to monitor indoors and outdoors at the same time. Management were unaware of this being environmental restraint within a secure unit.</p>	<p>Ensure that all egress doors are safe for use and are accessible for residents to utilise during the daytime.</p>

9. Summation Meeting

A summation meeting was attended by Jackie MacKenzie-Howe, Regional Manager, and Acting Facility Manager, Kim Brookes, Roving Facility Manager and newly appointed Temporary Facility Manager, Claire Tullet, Acting South Island Regional Manager, Tracey King Newley appointed Quality and Personnel Support Facility Manager, and Maryna Soper, Manager Radius Matura, Corrie Bronkhorst, Regional Manager Waikato, Mary Seymour -East, (Retiring) Regional Manager/ Educational Training Manager. Ann Marie Bailey, Senior Advisor, HealthCERT, Kerry Capelin, CNS Bay of Plenty DHB, and Lisa Rogers Owen, RN Bay of Plenty DHB.

The Senior Advisor thanked the facility for their participation and approach to the investigation, recognising that this was an unannounced inspection. It was explained that a full summation of findings could not be provided at the closing meeting as information gathered needed further analysis and some telephone interviews were to be followed up. The Senior Advisor confirmed that there would be findings against the Health and Disability Services Standards as per the above table.

The provider was advised that this investigation report would be published on the Ministry of Health website.