# Radius Residential Care Limited - Radius Heatherlea Care Centre

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

| | |
|---|---|
| **Legal entity:** | Radius Residential Care Limited |
| **Premises audited:** | Radius Heatherlea Care Centre |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| **Dates of audit:** | Start date: 4 July 2019 End date: 5 July 2019 |

**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

Heatherlea Care Centre is owned and operated by Radius Residential Care Limited and currently cares for up to 55 residents requiring rest home, hospital or dementia level care. On the day of the audit, there were 44 residents.

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

The manager is well qualified, experienced and has been in the role seven years. She is supported by an experienced clinical nurse manager and the regional manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

There were no shortfalls at this certification audit.

The service has been awarded a continuous improvement rating around activities.

## 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. |

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

## Organisational management

| | | |
|---|---|---|
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |

Radius Heatherlea is part of the Radius group and as such, there are organisational-wide processes to monitor performance. A facility manager and clinical nurse manager are responsible for day-to-day operations. There is a quality system that is being implemented in line with the organisational quality plan. Management and quality, infection control and health and safety meetings are used to monitor quality activities such as audit, complaints, health and safety, infection control and restraint. Residents receive services from suitably qualified staff. There is an adverse event reporting system implemented at Radius Heatherlea and monthly data collection monitors predetermined indicators. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service

education and competency assessments. There is a documented rationale for staffing the service. Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

| | | |
|---|---|---|
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | All standards applicable to this service fully attained with some standards exceeded. |

The registered nurses are responsible for each stage of service provision. Initial assessments, care plans and evaluations are completed by registered nurses within the required timeframes. Care plans and work logs (developed on the electronic resident system) are written in a way that enables all staff to clearly follow their instructions. The general practitioner reviews residents at least three monthly. There is allied health professional involvement in the care of the residents.

The activity programme is varied and interesting and includes outings, entertainment and links with the community. The rest home and hospital have an integrated programme. The activities in the dementia unit are flexible and meaningful. Cognitive stimulation therapy has been introduced.

Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. The GP reviews medication charts three monthly.

Meals and baking are prepared and cooked on site. The menu is varied and appropriate and has been reviewed by a dietitian. Individual and special dietary needs are catered for. Alternative options are provided. There are nutritious snacks available 24 hours.

## 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. |

The building has a current warrant of fitness. Reactive and planned maintenance is in place. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy. There is a mix of ensuites and communal toilets and showers. All resident rooms have hand basins. There is sufficient space to allow the safe movement of residents around the facility using mobility aids. There are communal dining rooms and lounges in the rest home/hospital and dementia care unit. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. The facility is appropriately cleaned. Personal clothing is laundered on site with other laundry completed by a contracted service. Emergency systems and equipment are in place in the event of a fire or external disaster. There is a first aider on duty at all times.

## Restraint minimisation and safe practice

| | | |
|---|---|---|
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator/clinical manager. During the audit, there was one resident using an enabler voluntarily and no residents with restraints. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

## 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. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. There is organisational benchmarking. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been two outbreaks since the last audit.

## 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** | 1 | 44 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 92 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

| Standard with desired outcome | Attainment Rating | Audit Evidence |
|---|---|---|
| Standard 1.1.1: Consumer Rights During Service Delivery<br><br>Consumers receive services in accordance with consumer rights legislation. | FA | Radius Heatherlea policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with ten care staff (five healthcare assistants across the three service levels, three registered nurses, one activities coordinator and one diversional therapist) confirmed their understanding of the Code. Five residents (three rest home level and two hospital level) and three relatives (one rest home level and two dementia level) interviewed, confirmed that staff respect privacy and support residents in making choices. |
| Standard 1.1.10: Informed Consent<br><br>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices | FA | Informed consent processes are discussed with residents and families on admission. The resident or their enduring power of attorney (EPOA) signs for written general consents. Advance directives and cardiopulmonary resuscitation status were sighted in the two rest home resident files (including one resident under long-term chronic health condition) and three hospital level resident files (including one younger person with a physical disability). The EPOA had been activated in the two dementia care resident files. Where residents were deemed incompetent, the GP had made a medically indicated not for resuscitation decision. Family members confirmed they were involved in decisions that affect their relative's lives. Care staff interviewed confirmed verbal consent is obtained when delivering care. All resident files contained a signed admission agreement. |

| | | |
|---|---|---|
| and give informed consent. | | |
| Standard 1.1.11: Advocacy And Support<br>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on residents' family/whānau and chosen social networks. Staff receive training on the Code and the role of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources<br>Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Relatives and friends are encouraged to be involved with the service and care. |
| Standard 1.1.13: Complaints Management<br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaint forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint's register that includes complaints received, dates and actions taken. There is evidence of lodged complaints being discussed in the facility (full staff) meetings. There were two complaints made in 2018 including one Health and Disability complaint and one complaint has been received in 2019 year to date. The HDC complaint has been closed with no further actions required. The facility manager signs off each complaint when it is closed. Complaints are being managed in a timely manner and meeting requirements determined by Health and Disability Commissioner. |
| Standard 1.1.2: Consumer Rights During Service Delivery<br>Consumers are informed of their rights. | FA | There is an information pack given to prospective residents and families that includes information about the Code and the Nationwide Advocacy Service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is |

| | | |
|---|---|---|
| | | included in the service agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect<br><br>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | A tour of the premises confirmed personal privacy for residents is ensured. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Care staff interviewed could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with healthcare assistants described how choice is incorporated into resident cares. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs<br><br>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The Māori health plan policy for the organisation references local Māori health care providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with community representative groups as requested by the resident/family. During the audit, there was one resident that identified as Māori living at the facility. The residents care plan includes preferences related to the resident's culture. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs<br><br>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, | FA | An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Seven resident files reviewed evidenced that individual beliefs or values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs. |

| | | |
|---|---|---|
| and beliefs. | | |
| Standard 1.1.7: Discrimination<br><br>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities. The monthly facility (full staff) meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers (regional manager, facility manager and clinical nurse manager) and care staff confirmed their awareness of professional boundaries. |
| Standard 1.1.8: Good Practice<br><br>Consumers receive services of an appropriate standard. | FA | The Radius quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. Policies and procedures have been reviewed and updated at organisational level and are available to staff. Outcomes for the service are monitored with benchmarking, using data from the electronic patient management system implemented across all Radius facilities. Feedback is provided to staff via the various meetings and through graphs and notices on the noticeboard in the staff room. There is a minimum of one RN on each shift. A physiotherapist is available for two hours a fortnight. Residents meetings have been conducted. Residents and relatives interviewed spoke positively about the care and support provided.<br><br>Radius Heatherlea is imbedding the Radius vision of exceptional care and exceptional people (EPEC) and all current staff had signed the Radius pledge. An enlarged copy of the pledge with all staff signatures on it, is displayed in staff areas. All staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the facility manager, clinical nurse manager and nursing staff. There are implemented competencies for HCAs and RNs. There are clear ethical and professional standards and boundaries within job descriptions. |
| Standard 1.1.9: Communication<br><br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. Twelve adverse events reviewed met this requirement when notification was appropriate. Family members interviewed confirmed they are notified following a change of health status of their family member. Bi-monthly resident/relative meetings provide a venue where issues can be addressed. There is an interpreter policy in place and contact details of interpreters were available. |
| Standard 1.2.1: | FA | Radius Heatherlea is part of the Radius Residential Care group. The service currently provides rest home, |

| | | |
|---|---|---|
| Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | | hospital and dementia level care for up to 55 residents. On the day of the audit there were 44 residents, 13 rest home, 11 hospital and 20 dementia level residents. This includes one hospital resident on a younger persons with disabilities (YPD) contract and one rest home resident on a long-term support chronic health condition (LTS-CHC) contract. There are 19 dual-purpose beds. All other residents were under the age-related residential care (ARRC) contract.<br><br>The Radius Heatherlea business plan '1 April 2018 to 31 March 2020' is linked to the Radius Residential Care group strategies and business plan targets. The mission statement is on display on resident noticeboards. An organisational chart is in place. Quarterly reviews are undertaken to report on achievements towards meeting business goals.<br><br>The facility manager has been in the role for seven years. She is supported by a clinical nurse manager, who has been in the role since December 2017 and an administrator who has been in the role for two and a half years. These three staff form the management triangle of support team. The regional manager also supports the facility manager in the management role and was present during the days of the audit.<br><br>The facility manager has maintained more than eight hours of professional development activities related to managing an aged care facility. |
| Standard 1.2.2: Service Management<br><br>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The clinical nurse manager/RN covers during the temporary absence of the facility manager. For extended absences, Radius has interim (roving) facility managers who cover facility manager absences. The regional manager is available on a consultative basis. |
| Standard 1.2.3: Quality And Risk Management Systems<br><br>The organisation has an established, documented, and | FA | There is an organisational quality/risk management plan that includes: clinical/care related risks; human resources; health and safety; environmental/service; financial; as well as site specific risks/goals identified for Radius Heatherlea. Quality and risk performance are reported across facility/quality meetings and to the regional manager. Discussions with the managers and staff reflected staff involvement in quality and risk management processes. 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. There are clear guidelines and templates |

| | | |
|---|---|---|
| maintained quality and risk management system that reflects continuous quality improvement principles. | | for reporting.<br><br>The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are implemented when opportunities for improvements are identified (eg, internal audit results are lower than 95% compliance). Resident and family meetings are held bi-monthly. An annual resident/relative survey was completed in February 2019. The overall satisfaction rate showed improvement from the 2018 results. The results of a food satisfactory survey completed in April 2019 was 100% positive.<br><br>The service has policies and procedures and associated implementation systems, adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level by the Clinical Nurse Managers Group with input from facility staff every two years. Clinical guidelines are in place to assist care staff.<br><br>Health and safety policies are implemented and monitored by the Health and Safety committee. Two health and safety representatives (an HCA and the head cleaner) were interviewed about the health and safety programme. Health and safety representatives have completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.<br><br>Falls prevention strategies are in place including sensor mats, high low beds and intentional rounding. |
| Standard 1.2.4: Adverse Event Reporting<br><br>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 | There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. They are signed off by the facility manager or clinical manager when complete. A review of twelve accident/incident forms identified that forms are fully completed and include follow up by a registered nurse. Accident/incident forms are completed when a pressure injury is identified. The facility manager and regional manager were able to identify situations that would be reported to statutory authorities including (but not limited to): infectious diseases, serious accidents and unexpected death. |
| Standard 1.2.7: Human Resource Management<br><br>Human resource | FA | Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one clinical nurse manager, one RN, two healthcare assistants, one diversional therapist and one kitchen manager) included a recruitment process (interview process, reference checking, police check), signed |

| | | |
|---|---|---|
| management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | | employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.<br><br>The orientation programme provides new staff with relevant information for safe work practice. An education and training plan is being implemented and includes in-service education and competency assessments. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction. These competencies are repeated annually.<br><br>Twenty three of 24 healthcare assistants work in the dementia unit. Nineteen have completed the dementia standards. The other four healthcare assistants have commenced the standards, and all have been at the facility for less than 18 months. Registered nurses are supported to maintain their professional competency. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies. There are two interRAI trained registered nurses including the clinical nurse manager. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A policy is in place for determining staffing levels and skills mix for safe service delivery. Residents and family members interviewed reported there are sufficient staff numbers. There is a full-time facility manager and clinical nurse manager who work from Monday to Friday. The hospital/rest home beds are rostered as one unit and the dementia unit is rostered separately.<br><br>The hospital/rest home unit has 24 residents (13 rest home and 11 hospital) and there is an RN on duty each shift. The RN is supported by adequate numbers of HCAs. There are three HCAs on duty on the morning (two long and one short) shift and three on duty on afternoon shift (two long and two short) and two on the night shift.<br><br>The dementia unit has 20 residents, there are two HCAs on duty working full shifts on both morning and afternoon. There is one HCA on the night shift, supported as required by one of the HCAs from the hospital/rest home unit. Staff working on the days of the audit, were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. The RNs on duty in the rest home/hospital area also cover the dementia unit and the clinical nurse manager also spends hours within the unit. In the dementia unit, staff stated that overall, the staffing levels are satisfactory and that the managers provide good support. Interviews with residents and relatives confirmed staffing overall was satisfactory. |
| Standard 1.2.9: Consumer Information Management Systems<br><br>Consumer information is uniquely identifiable, accurately recorded, | FA | The residents' files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record on the computer-based system. Personal resident information is entered into an electronic system which is confidential and cannot be accessed by unauthorised personnel. Entries into the computer-based system are able to be identified, dated and timed. |

| | | |
|---|---|---|
| current, confidential, and accessible when required. | | |
| Standard 1.3.1: Entry To Services<br><br>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has admission policies and processes in place. Residents/relatives receive an information pack outlining services provided, including the dementia level of care. Needs assessors are involved in the pre-entry screening for all residents. The facility manager/registered nurse and/or the clinical nurse manager screens potential residents prior to entry to ensure the service can meet the potential residents assessed needs. Seven admission agreements reviewed align with the requirements of the Age-Related Residential Care agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer<br><br>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policies and procedures comply with medication legislation and guidelines. Registered nurses and senior HCAs administer medications and have completed annual medication competencies and medication education. All medications are stored safely within one main medication room in the facility. Medications are delivered in robotic packs and checked against the medication chart. All medications were within the expiry date. All eye drops in use were dated on opening. There were no self-medicating residents. There is a bulk supply of medications for hospital level use only. Fourteen medication charts (paper-based) were reviewed and met prescribing requirements. All medication charts identified an allergy status and had photo identification. The GP had reviewed medication charts at least three monthly. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | FA | All food and baking are prepared and cooked on site. Two kitchen managers/qualified cooks work across the seven days. They are supported by morning and afternoon kitchenhands. The four weekly menu has been reviewed by a dietitian. The kitchen manager receives resident dietary information for new admissions and updates with new changes. Dietary requirements are accommodated including vegetarian, pureed meals and |

| | | |
|---|---|---|
| A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | | diabetic desserts. Alternative foods are provided for any resident dislikes. The kitchen is adjacent to the main dining room and served from a bain marie. Meals are plated and delivered in hot boxes to the upstairs dining room and dementia unit dining room. There is special equipment available for residents if required. There are nutritious snacks available 24 hours in the dementia care unit.<br><br>The food control plan has been verified and expires 31 March 2020. The temperatures of refrigerators, freezers and chiller are monitored and recorded daily. End-cooked food temperatures are taken and recorded daily. Incoming chilled goods temperatures are recorded. All food is stored appropriately and dated. A cleaning schedule is maintained. Residents and the family members interviewed commented positively about the quality and variety of food served. |
| Standard 1.3.2: Declining Referral/Entry To Services<br><br>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau and the referring agency. Reasons for declining would be if there were no beds available or the service could not meet the assessed needs. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment<br><br>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. Initial risk assessments are completed on admission with documented interventions to provide the required support. InterRAI assessments are completed within 21 days of admission for long-term residents under the ARC and six monthly as part of the review process. InterRAI assessments are completed for any significant change in health status as sighted. The outcomes of assessments were reflected in the long-term care plans in resident files reviewed. |
| Standard 1.3.5: Planning<br><br>Consumers' service delivery plans are consumer focused, | FA | Seven long-term care plans reviewed all describe the support required to meet the resident's goals and needs as identified through the assessment process. Residents and relatives confirmed they were involved in the care planning and review process. There is documented evidence of resident/relative involvement in the development of care plans. Care staff interviewed reported the electronic care plans are readily available and they found the plans easy to follow. Care plans identified allied health input into resident care including GP, hospice, |

| | | |
|---|---|---|
| integrated, and promote continuity of service delivery. | | physiotherapist, gerontology nurse specialist and dietitian. |
| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Registered nurses and HCAs follow the detailed and regularly updated care plans and report progress against the care requirements each shift. If a resident's health status changes the RN initiates a GP or nurse specialist review. Relatives interviewed stated they are contacted for any changes in the resident's health, and family discussion is documented in the electronic progress notes.<br><br>Staff have access to sufficient medical supplies including dressings. Seven (one chronic wound, one skin condition and five skin tears) of 13 wounds were reviewed. Wound assessments including body map, wound size and photo were in place. Evaluations were completed at the required frequency and include dressing types. There were no pressure injuries on the day of audit. There is access to the DHB wound nurse specialist if required.<br><br>Electronic monitoring forms are completed as directed through the electronic worklogs and include turning charts, pain monitoring, food and fluid charts, blood pressure, weight charts, weekly weight, behaviour charts, blood sugar levels, neurological observations and hourly resident checks. |
| Standard 1.3.7: Planned Activities<br><br>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. | CI | A registered diversional therapist (DT) has been in the role for five years and works from 8 am to 4 pm Monday to Friday. The DT oversees the activity integrated rest home/hospital programme and separate programme for the dementia unit. She is supported by an activity's coordinator 10 am to 5 pm Monday to Friday. The DT and activity coordinator rotate through the rest home/hospital areas with a set 4 pm to 5 pm programme implemented in the dementia care unit daily. The HCAs working in the dementia unit incorporate activities for residents into their role. There are adequate resources for healthcare assistants. Personalised activity boxes with meaningful items have been introduced for residents in the dementia unit. The activity programme for dementia care residents is flexible and focused on meaningful activities, small group activities, one-on-one time and reminiscing. There are several locations where group activities occur including lounges, dining rooms and a large activity room. The programme is planned a month in advance and has a monthly theme, for example, the theme for July is "friendship". The rest home and hospital programme are integrated and includes music and sing-a-longs, board games, newspaper reading, baking, arts, walks, gardening, hand massage, poetry, reminiscing and happy hours. One-on-one time is spent with residents who choose not to or are unable to participate in group activities. The service has successfully introduced small group cognitive stimulation therapy sessions for residents with mild to moderate dementia.<br><br>Community visitors include entertainers and guest speakers. Residents from the dementia unit attend group activities in the rest home/hospital as appropriate and under supervision. There are weekly outings for all residents that include scenic drives, shopping, café outings and garden centres. There are inter-home social |

| | | |
|---|---|---|
| | | activities.<br><br>All resident files reviewed on the electronic system have an individual life history and leisure care plan that is evaluated at least six monthly in consultation with the multidisciplinary team. There are two monthly resident meetings that are open to families to attend. Residents and families interviewed commented positively on the activity programme. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial interim care plans are evaluated by the RNs in consultation with the resident/family within three weeks of admission. Electronic evaluations (multidisciplinary – MDT case conference) are completed at least six monthly with input from the resident/relative, GP and care staff. Evaluations against the resident goals identify if the goals have been met or unmet and the care plan updated to reflect the resident's current needs and supports. In the electronic files reviewed the long-term care plan had been evaluated six monthly for residents who had been at the service six months. There is at least a three-monthly review by the GP. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)<br><br>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists as required. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in clinical notes. There was evidence where a resident's condition had changed the resident had been reassessed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances<br><br>Consumers, visitors, and service providers are protected from harm | FA | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available, and staff were observed wearing personal protective clothing while carrying out their duties. Chemicals sighted, were labelled correctly and stored safely throughout the facility. Safety data and product sheets were available. Staff have completed chemical safety training. The organisation is actively looking for cost effective ways to reduce the overall carbon footprint in waste management, and staff at Heatherlea have been implementing strategies to reduce landfill waste. |

| | | |
|---|---|---|
| as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | | |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 1 September 2019. The facility is a three-level building with a stair and lift between the first two levels and gradual ramp access and entrance to the dementia care unit. There is a full-time maintenance person who addresses the repairs and maintenance requests submitted on the electronic management system. There is a monthly planned maintenance schedule for the internal and external building. Essential contractors are available 24-hours. Hot water temperatures in resident areas are monitored monthly. Corrective actions were sighted where temperatures were higher than 45 degrees Celsius. Electrical equipment has been tested and tagged and clinical equipment has been calibrated. Resident rooms are refurbished as they become vacant.<br><br>The facility has sufficient space for residents to mobilise using mobility aids. There is sufficient space in communal areas for residents to sit safely in lounge chairs. External areas include grounds with seating and shade that are well maintained and easily accessible. Environmental improvements include modernisation of the décor, new carpet in the communal areas and corridors, new vinyl in the dining rooms and new tables, installation of a new call bell system and new van exterior paintwork portrays Taranaki.<br><br>Staff stated they had sufficient equipment to deliver the cares as outlined in the resident care plans.<br><br>The dementia care unit is spacious and has safe access to the outdoor gardens and courtyard from the communal lounge. The garden area has been upgraded with raised gardens and mural on the fence. There is seating and shade available. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities<br><br>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or | FA | There are adequate communal showers with vacant/engaged signs and/or privacy locks. All rooms have hand basins. Larger dual-purpose rooms have ensuites. Communal toilets were closely located to bedrooms without ensuites. Flooring and fixtures are appropriate and made of materials for ease of cleaning. |

| | | |
|---|---|---|
| receiving assistance with personal hygiene requirements. | | |
| Standard 1.4.4: Personal Space/Bed Areas<br><br>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents' rooms are single and allow for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day audit. The service has introduced personalised activity boxes in resident rooms in the dementia unit that helps residents recognise their rooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br><br>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The communal areas in the rest home area include a large dining room and separate lounge along with a separate recreational room. In the dementia unit there is a roomy lounge with adjacent dining room and kitchenette. Seating and space is arranged to allow both individual and group activities. A domestic area has been developed within the dementia area where residents can have access to domestic activities. In the hospital there is a lounge/dining room and seating alcoves in the upstairs area. |
| Standard 1.4.6: Cleaning And Laundry Services<br><br>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being | FA | All laundry, other than personal clothing, is laundered off site. There is a laundry person employed Monday to Friday. The on-site laundry has a dirty/clean area. Dirty laundry is collected in laundry bags and placed in an outside storage shed for collection by the commercial laundry. Clean laundry is delivered into a central linen cupboard and distributed to the units. There was adequate linen sighted on the day of audit.<br><br>There are two cleaners employed seven days a week. The cleaning trolleys were well equipped and have a locked chemical box. Chemicals are pre-mixed through a dispensing system. The staff have access to a range of chemicals, cleaning equipment and protective clothing. Laundry and cleaning staff have completed chemical safety, annual infection control education and health and safety training. The chemical provider monitors the use and effectiveness of laundry and cleaning chemicals and data safety sheets and information on the use of chemicals was available in all relevant areas. The facility was well maintained and clean on the days of audit. |

| | | |
|---|---|---|
| provided. | | Residents interviewed were satisfied with the cleanliness of their rooms and environment. The standard of cleanliness and laundry process is monitored through the internal audit programme. |
| Standard 1.4.7: Essential, Emergency, And Security Systems<br><br>Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an emergency health management plan in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Heatherlea has an approved fire evacuation plan dated 12 October 1999. Fire evacuation drills occur six monthly with the last evacuation drill occurring on 30 May 2019. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (BBQ). The service has a backup system for emergency lighting and battery backup. Arrangements are in place for the provision of a generator if required.<br><br>Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are available. There are civil defence kits in the facility that are checked two monthly. There is sufficient water (water tanks and potable water) stored to ensure for three litres per day for three days per resident. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitors' book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating<br><br>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and all resident rooms are appropriately heated and ventilated. All rooms including communal lounges and dining rooms have external windows that open, allowing plenty of natural light. Some of the dementia unit resident rooms open out onto the courtyard. The resident bedrooms and communal areas were heated and the environmental temperature warm and comfortable. |
| Standard 3.1: Infection control management<br><br>There is a managed environment, which minimises the risk of | FA | Radius Heatherlea has an established infection control programme (last review June 2019). The clinical nurse manager is the designated infection control nurse with support from the regional manager (RN).<br><br>Visitors are asked not to visit if they are unwell. There are hand sanitisers appropriately placed throughout the facility. Outbreak kits are readily available. |

| | | |
|---|---|---|
| infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | | |
| Standard 3.2: Implementing the infection control programme<br><br>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The clinical nurse manager is the designated infection control (IC) coordinator since commencing in December 2017. The infection control coordinator has attended an infection control course at the Taranaki District Health Board and completed online MOH training. There are adequate resources to implement the infection control programme.<br><br>The IC coordinator has good external support from the local laboratory, bug control advisory service, the health protection department at Taranaki hospital, infection control nurse specialist at the DHB, the regional manager and the GPs. |
| Standard 3.3: Policies and procedures<br><br>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are Radius infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed in June 2019. |

| | | |
|---|---|---|
| Standard 3.4: Education<br>The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator ensures all new staff are orientated to infection control as part of the orientation programme and at least annually thereafter. Infection control training and hand hygiene audits are completed by all staff. Topical toolbox talks are also provided.<br>Resident education is expected to occur as part of providing daily cares. |
| Standard 3.5: Surveillance<br>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 policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme. Infections by type are collated monthly and reported to the combined quality, health and safety and infection control meetings. Data is analysed for trends and corrective actions. Meeting minutes and graphs are displayed for staff reading. Infection control is an agenda item on all facility meetings. The service submits data monthly to Radius head office where benchmarking is completed.<br>There have been two gastroenteritis outbreaks in May and December 2019. Case logs and the notification to the DHB health protection officer were sighted. |
| Standard 2.1.1: Restraint minimisation<br>Services demonstrate that the use of restraint is actively minimised. | FA | Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The clinical nurse manager is the restraint coordinator. There were no residents on restraint and one hospital level resident with an enabler on the day of audit. The resident file was reviewed where an enabler (lap belt) was in use. Voluntary consent and an assessment process were completed. The enabler is linked to the resident's care plan and is reviewed three-monthly. Staff complete restraint questionnaires and education annually. |

# 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.

| No data to display |
|---|

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

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
|---|---|---|---|
| Criterion 1.3.7.1<br>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The service identified a need for small group activities for residents living with mild to moderate dementia as some residents were withdrawing socially and unmotivated in participating in group activities. Cognitive stimulation therapy sessions were introduced in January 2019 and have been successful in engaging the residents in activities of their choice and interest, which has improved in reducing social isolation and improving | Cognitive stimulation therapy (CST) is a recognised evidence-based programme for residents with dementia. The facilitator of CST at Heatherlea (activity coordinator) attended an approved training programme before commencing CST. Resources were acquired including manuals (published by The Journal of Dementia Care) for caregivers and group leaders for the initial 14 sessions and a maintenance programme. A variety of meaningful activities were included in the initial 14 sessions, focusing on physical, mental, social and psychological improvement for residents living with dementia. Each new activity was evaluated with the residents to monitor if residents enjoyed the activity and most felt they benefited from the activity. Monitoring progress forms were maintained for each resident against interest; communication, enjoyment and mood. Not all residents in the group could verbalise their feedback, however there was positive family feedback and testimonials sighted. The CST viewer was used to graph each residents progress. The outcome demonstrated the CST programme had been successful. The service then continued with a maintenance programme for the rest home/hospital residents who had completed the initial 14 sessions, however attendance is by choice. The programme has extended to small group and one-on-one therapy in the dementia care unit. |

| | | | |
|---|---|---|---|
| | | enjoyment for each of the participants. | |

End of the report.