

Inspection Report

Kaylex Care Limited - Eastcare Residential Home

Date of inspection: 18 June 2009

HealthCERT
Quality & Safety
Sector Accountability and Funding
Ministry of Health

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Undertaken 18 June 2009

File Ref: WKA18

Provider: Kaylex Care Limited – Eastcare Residential Home

Contact Person: XXX XXX (Manager)

Premise: 194 Nixon Street
Hamilton East

Executive summary

The Ministry of Health received a complaint from Mrs XXX XXX of the Victoria Central Accident and Medical Centre as a follow-up request by the attendant doctor, Dr XXX XXX. The complaint was about the care provided to Mrs XXX XXX, a resident of Eastcare Residential Home. If substantiated, such concerns may be in breach of Kaylex Care Ltd's obligations as a certified provider under the Health and Disability Services (Safety) Act 2001 ("the Act").

The complaint alleges that on 16 May 2009 three caregivers took Mrs XXX to a medical centre by car after she was found in an unresponsive state. On arrival at the medical centre, Mrs XXX was found to have a GCS of 7 and hypothermia. The doctor at the medical centre also suspected that Mrs XXX had a fractured left neck of femur.

The complaint relates but is not limited to the following Health and Disability Services (Core) Standards (HDSS):

- HDSS 1.1 Consumer Rights
- HDSS 1.2 Organisational Management
- HDSS 1.3 Continuum of Service Delivery
- HDSS 1.4 Safe and Appropriate Environment

An unannounced inspection was undertaken by HealthCERT on 18 June 2009. The inspection identified Eastcare Residential Home is a facility that has a newly refurbished 19 bed dementia unit. There is one double room shared by a husband and wife and the remainder are single rooms, 49 in total. The resthome includes the original buildings and is joined to an extension, which comprises the dementia wing.

There was concern that there were residents who required further assessment to determine whether they are appropriately placed in the facility. Residents in the rest home were identified as requiring demential level care. HealthCERT has consulted with the DHB/ NASC about these residents.

Matters of contractual compliance have been referred directly to Waikato District Health Board.

Further information was also requested from the manager in order to complete the inspection. This was subsequently received on the 7 July 2009.

Corrective actions

The following corrective actions are required:

1. To be compliant with Health and Disability Services Standard 1.1.3 undertake actions to ensure privacy, within the shared double room.
2. To be compliant with Health and Disability Services Standard 1.1.8 treatment protocols and procedures are based on evidence-based rationales, which are monitored and evaluated. This should include but is not limited to:
 - ensuring that clinical staff are given appropriate training or have access to current clinical expertise, eg Wound Care, Continence Management, Medicine Management.
3. To be compliant with Health and Disability Services Standard 1.1.9 & 1.1.10 notation in residents records identifies family involvement, demonstrating involvement of family or the resident's representative (as appropriate) in all stages of service provision. This should include but is not limited to:
 - ensuring that communication with family/whanau occurs and is clearly documented
 - ensuring family/whanau involvement with care planning occurs and is clearly documented
 - notification of incidents or accidents
 - notification of a change in condition of a resident (e.g. unexplained weight loss).
4. To be compliant with Health and Disability Services Standard 1.2.1 a review of the existing quality plan identifies Quality Improvement. This should include but is not limited to:
 - ensuring that the Quality and Risk Plan involves closure of the quality loop, corrective action plans and evaluation of processes.
5. To be compliant with Health and Disability Services Standards 1.2.2:
 - Continence management and assessment is reviewed in line with best practice and the provision of adequate continence products.
 - Medication procedures and management are reviewed to ensure compliance with policy and legislative requirements.
 - Staffing levels and skill mix are reviewed especially in the dementia unit and for activities and cleaning.
 - A maintenance plan is formulated, monitored and evaluated at least yearly.
 - Equipment and chattels are evaluated and replaced or repaired routinely.
6. To be compliant with Health and Disability Services Standard 1.2.3. document in sufficient detail assessment, planning, service delivery, evaluation and review for each resident that clearly shows that residents needs have been identified and services appropriately provided. This should include but is not limited to:

- ensuring a process is implemented to monitor the effectiveness of delivery of care in accordance with required standards
 - collecting, analysing and identifying trends and variances associated with service delivery as part of the quality improvement process
 - developing corrective action plans where a deficit has been identified and requires action to prevent or limit the risk of recurrence
 - documenting and undertaking corrective action planning and evaluation as part of the quality improvement process.
7. To be compliant with Health and Disability Services Standard 1.2.4 appropriate assessment and treatment recordings are documented for residents in the event of an untoward event (e.g. resident fall) and for regular monitoring of the wellbeing of residents (e.g. monthly weights). This should include but is not limited to:
- ensuring that incidents, accidents and other untoward events are analysed in a timely manner
 - undertaking trend analysis associated with individual residents and trend analysis associated with the facility as a whole
 - linking the analysis back to a quality improvement system
 - ensuring each resident's file verifies that all relevant assessments have been completed and where appropriate further assessments are scheduled to occur as part of monitoring the progress of the resident
 - documenting adverse, unplanned or untoward events in order to identify opportunities to improve service delivery and manage risk.
8. To be compliant with Health and Disability Services Standard 1.2.7 ensure that competent service providers with the appropriate skills are employed.
- Ensure that staff working in the dementia unit have been trained in this unit standard.
 - Ensure that education needs are identified for all staff (this to include RN staff) and associated timeframes to include best current practice presented by qualified personnel, i.e. fire safety training by fire service personnel.
9. To be compliant with Health and Disability Services Standard 1.2.8
- Revise allocation of hours for diversional therapy, and training/expertise of diversional therapy staff.
 - Revise the allocation of staff to ensure suitably qualified staff are rostered to the dementia unit and sufficient staff are on duty to provide competent and safe care in order to meet the needs of residents.
10. To be compliant with Health and Disability Services Standards 1.3.3; 1.3.6:
- Provide documented evidence of the involvement of the resident and their family in the development of care planning and ongoing progress.
 - Ensure recordings are documented for residents accounting for:
 - appropriate assessment and treatment in the event of an untoward event (e.g. resident fall)
 - regular monitoring of the wellbeing of residents

- Ensure care and care requirements are sufficiently documented to demonstrate that needs of resident's are met.
 - Ensure the frequency and nature of reporting is appropriate to the degree of risk associated with the care and services required by each resident.
 - Ensure coordination of services for residents includes a multi-disciplinary approach where appropriate. This should include but is not limited to:
 - Involving a range of health professionals to support decision making where a resident is not progressing as expected or would benefit from a multidisciplinary approach to plan services
 - Involving family in planning and regular reviews with the resident
 - Ensure each resident care plan is current and appropriate
11. To be compliant with Health and Disability Services Standard 1.3.4:
- Ensure each resident file will verify that all relevant assessments have been completed and where appropriate further assessments are scheduled to occur as part of monitoring the progress of the resident.
12. To be compliant with Health and Disability Services Standard 1.3.5:
- Ensure care plans adequately reflect the interventions required to meet the assessed needs of residents and their associated goals.
 - Ensure each resident care plan is current, and reflects the needs of residents.
 - Ensure that clinical files for residents are integrated. This should include but is not limited to having current care plans, progress notes, assessments and incident or accident forms held as one file.
13. To be compliant with Health and Disability Services Standard 1.3.8:
- Ensure a documented evaluation of care indicating achievements towards identified goals occurs at scheduled intervals or in response to a change in need of a resident
 - Ensure that where progress is less than expected for a resident that this results in the formulation of a short term care plan or revision of the life style plan where goals and interventions are developed against the assessed need. This includes but is not limited to:
 - weight loss
 - wounds
 - infections
 - challenging behaviour
 - change in mobility
 - change in continence
 - change in hydration status.
14. To be compliant with Health and Disability Services Standard 1.3.9:
- Ensure appropriate facilitation of referral to other services where this is indicated including referral to the Needs Assessment Coordination Service.
15. To be compliant with Health and Disability Services Standard 1.3.12. This should include but is not limited to:

- ensuring safe medication management practices are implemented within the service.
 - returning relabelled/ unlabelled stock and medications for PRN non specific labelled for resident to the pharmacy
 - ensuring eye drops to be dated for discard upon opening.
 - establishing a system which promptly provides each person with appropriate treatment for adverse effects or side effects of medication
 - ensure service providers responsible for medicine management are competent to perform the function for each stage they manage.
 - Documentation of all current medicines prescribed
16. To be compliant with Health and Disability Services Standard 1.3.13. This should include but is not limited to:
- Ensure adequate cleaning of all kitchen areas
 - Ensure all dry foods are correctly labelled/dated.
17. To be compliant with Health and Disability Services Standard 1.4.2.3:
- Ensure (particularly in a dementia unit) that the control of temperature via heating/cooling systems is able to be maintained by staff, and is monitored.
18. To be compliant with Health and Disability Services Standard 1.4.6:
- Ensure cleaning occurs to an acceptable standard.
19. To be compliant with Health and Disability Services Standard 1.4.7 the registered nurse on call for the facility maintains documentation of evaluation and follow up of after hours calls and the advice given.
- Ensure that policy and procedure is reviewed and followed, and that documentation and evaluation is carried out.
20. To be compliant with Health and Disability Services Standard 1.4.8
- Ensure that maintenance is carried out per a plan and that this is reviewed at least annually.
 - Ensure that heating and hot water are assured throughout the facility
21. To be compliant with Health and Disability Services Standard 2.2.1
- Ensure that the main rest home area is not fully locked with residents/visitors requiring assistance or a key pad number to exit.
 - Residents requiring PRN medication for challenging behaviour are monitored for adverse reactions.
 - Ensure in assessing whether restraint will be used, appropriate factors are taken into consideration.
 - Ensure appropriate facilitation of referral to other services where this is indicated including referral to the Needs Assessment Coordination Service.

- Ensure the consumer's physical and psychological health, including any adverse health effects i.e. medication adverse effects or side effects are assessed, monitored and appropriately provides each person with treatment.

Additional Conditions

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.

The following conditions are to be included on the certification schedule of Kaylex Care Limited- Eastcare Residential Home

1. A written progress report that outlines all actions undertaken by the Provider in relation to Corrective Actions 1, 15, 16, 17, 18, 18, & 20 (HDSS 1.1.3; 1.3.12; 1.3.13 ;1.4.2.3; 1.4.6; 1.4.7; 1.4.8; 2.2.1) as identified in the Inspection Report must be submitted to the Director-General by 27 August 2009.
2. A written progress report that outlines all actions undertaken by the Provider in relation to Corrective Actions 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, & 13, (HDSS 1.1.8; 1.1.9; 1.1.10; 1.2.1; 1.2.2; 1.2.3; 1.2.4; 1.2.7; 1.2.8; 1.3.3; 1.3.4; 1.3.5; 1.3.6; 1.3.8;) as identified in the Inspection Report must be submitted to the Director-General by 27 October 2009.
3. HealthCERT may elect to carry out a verification audit in relation to these corrective actions
4. The Director-General may impose any further condition, or vary any condition, where the Director-General thinks it is necessary or desirable to do so in order to help achieve the purposes of the Act.

Background

Kaylex Care Limited – Eastcare Residential Home is certified under the Act to provide rest home care services for a period of 3 years, expiring on 26 April 2010.

Before this, the provider applied for certification in April 2004 and was certified for three years. In the 2004 certification audit, two corrective actions were required. In the 2007 recertification audit, one corrective action was identified.

A routine surveillance audit was carried out on 24 September 2008. A provisional audit occurred on the same day following alterations and modifications to the premises. No corrective actions were required.

Complaints

December 2005 – complaint from XXX XXX about various aspects of care provided. Waikato DHB followed up with provider. The DHB was satisfied with policies and procedures in place.

15 August 2008 – complaint from XXX XXX regarding management of scabies, and care provided to parents XXX and XXX XXX. The DHB took lead to resolve issues. The DHB followed up with public health and GP liaison services because there appeared to be failures of some GPs around diagnosis of scabies.

27 March 2009 – anonymous complaint about management of scabies outbreak. HealthCERT investigated and was satisfied with evidence provided. No further action required.

Nature of current complaint

18 May 2009 – Complaint from XXX XXX about care provide to Mrs XXX XXX.

On 16 May 2009 XXX XXX, a resident of Eastcare Residential Home, was allegedly taken in a car by three caregivers to an after-hours medical centre after she was found in an unresponsive state. The caregivers said they found Mrs XXX unresponsive about 7am. They arrived at the medical centre about 8.30am. The complainant, the nurse manager at the medical centre, stated that Mrs XXX was unresponsive, had hypothermia, had a GCS of 7, and had a temperature of 31.3 degrees. After examination, Mrs XXX was transferred to Waikato Hospital about 9am.

The doctor at the medical centre suspected that Mrs XXX had a fracture in a bone on her left side and that she had possibly fallen due to a stroke.

Further information from the DHB

On 21 May 2009 XXX XXX, Portfolio Manager, Waikato DHB, advised that Kaylex Care Ltd was last audited against its DHB contract in 2006/07 and is next due for its contractual audit in 2010/11.

XXX XXX advised that the DHB had not received the complaint about the care provided to XXX XXX. However, she believed, this latest incident warranted further investigation by HealthCERT.

The following conditions of certification are required for all services certified under the Act:

- The provider is required to advise the Director-General of Health, by written notification, of the provider's intention to increase the number of beds provided in the organisation, prior to these beds being used to accommodate consumers.
- The Director-General of Health may impose any further condition, or vary any condition, where the Director-General of Health thinks it is necessary or desirable to do so in order to help achieve the purpose of the Act.
- If requested in writing by the Director-General of Health, the provider must provide any information about the provision of the health or disability services specified in the request.
- The provider is required to advise the Director-General immediately, by written notification, of any change to the manager (as defined in Health and Disability Sector Standard 2.1.3) of the organisation.

- The provider is required to advise the Director-General of Health, by written notification, of the provider's intention to reconfigure the kinds of services being provided in any premises listed on its certificate. This includes:
 - the addition of any kind of service that was not being provided at the premises at the time of the issue of the certificate;
 - changes in bed capacity for the kinds of services being provided at the premises at the time of the issue of the certificate;
 - the addition of any dedicated unit to meet the special needs of a consumer group, or changes to the bed capacity of the unit.
- The provider must inform the Director-General of Health of any change of designated auditing agency, within one week of such a change occurring.

Service Description

Kaylex Care Limited – Eastcare Residential Home provides Aged Residential Care Resthome services (including dementia care) in Hamilton. The occupancy and capacity is outlined below:

Area	Occupied	Capacity
Dementia	14	19
Rest Home	27	30
Total	34	49

Reasons for the inspection

The purpose of the inspection was to determine whether health care services being provided by Kaylex Care Limited – Eastcare Residential Home, are being provided in compliance with section 9, of the Health and Disability Services (Safety) Act that is a person providing health care services of any kind must do so whilst meeting all relevant standards.

Health and Disability service providers are required under section 9 of the Health and Disability Services (Safety) Act 2001 (the Act) to provide services:

- while certified by the Director-General to provide health care services of that kind; and*
- while meeting all relevant service standards;*
- in compliance with any conditions subject to which the person was certified by the Director-General to provide health care services of that kind; and*
- in compliance with this Act.'*

The inspection team

The inspection was undertaken by Marion McLauchlan, Team Leader HealthCERT, and XXX XXX, Senior Advisor HealthCERT, under the delegated authority of the Director-General of Health.

Methodology

The inspection was conducted to investigate the complaint made to the Ministry of Health that may have resulted in systems failures and non-compliance against the Health and Disability Sector Standards. The scope of the inspection was widened as a result of issues noted on the tour of the facility.

Findings are according to the Health and Disability Sector Standards NZS8134:2001.

Methods for obtaining evidence included inspection, document and report review, observation, inquiry, confirmation and verification.

Risk in relation to non-compliance has been assessed utilising the New Zealand Standards risk classification system. Attainment levels are assigned as either fully attained (FA), partially attained (PA) or unattained (UA).

The inspection was conducted utilising the following methods:

- Individual staff interviews – Individual staff interviews – 6 (manager, clinical manager - activities coordinator, care givers) staff were formally interviewed.
- Relative/ Resident interviews – 2 relatives were formally interviewed.
- Residents- Several residents were informally greeted and general conversations undertaken to the extent possible in a dementia setting.
- Observation: During facility tours and casual observation of the facility
- Document review: See the appendix for a list of documents that were requested as part of the audit process.
- Clinical Notes review: A sample of 10 subsidised residents' notes from the facility was audited.

This inspection did not constitute a full audit against the Health and Disability Services Standards 2008.

Limitations

The Health and Disability Services (Safety) Act, requires that A person providing health care services of any kind must do so while meeting all relevant service standards.

Section 40 delegations enable HealthCERT to:

- enter and inspect
- take possession of any equipment / device
- inspect any document
- take or make copies.

Section 43 Authorised person may require any person appearing to be in charge of, employed in or undertaking or recently having undertaken any work to answer any questions about:

- Health and safety of consumers
- Persons are not required to answer questions if the answer may tend to incriminate him or her.

However it is an offence under section 54(2) to

- intentionally obstruct, hinder or resist and authorised person exercising or attempting to exercise powers under the act; or
- intentionally fails to answer a question (other than a question whose answer may tend to incriminate the person); or
- when asked a question by an authorised person, gives an answer the person knows to be false or misleading

Opening meeting

On arrival the manager was present and XXX XXX provided an unannounced inspection letter that outlined the nature of the complaint to the manager and requested that the manager read this carefully and then ask any questions before the commencement of the audit.

The manager was unable to accompany the tour of the facility due to a doctors visit, but arranged for the Registered Nurse, XXX XXX to do so. An opening meeting was attended by XXX XXX (Manager), XXX XXX, XXX XXX and Marion McLauchlan. The meeting commenced at 10am and concluded at 10.30 am. The introduction meeting covered the following points:

Explanation of purpose of visit Section 40 (1) (b) **To determine whether health care services being provided by Kaylex Care Limited – Eastcare Residential Home are being provided in compliance with section 9 Health and Disability Services (Safety) Act, that is A person providing health care services of any kind must do so while meeting all relevant service standards.**

Delegations section 40:

- Enter and inspect
- Take possession of any equipment / device
- Inspect any document
- Take or make copies
- Section 43 Authorised person may require any person appearing to be in charge of, employed in or undertaking or recently having undertaken any work to answer any questions about:
 - Health and safety of consumers
 - Persons are not required to answer questions if the answer may tend to incriminate him or her.
 - However it is an offence under section 54 (2) to

- intentionally obstruct, hinder or resist and authorised person exercising or attempting to exercise powers under the act; or
- intentionally fails to answer a question (other than a question whose answer may tend to incriminate the person); or
- when asked a question by an authorised person, gives an answer the person knows to be false or misleading

A proposed agenda for the day was discussed including a request to interview any relatives or health professionals visiting the facility during the course of the day. The inspection commenced with a tour of the facility.

Complaint Specific Investigation Report

Complaint

On 18 May 2009 the Ministry received a complaint from XXX XXX, Nurse Manager, Victoria Central Accident & Medical, Hamilton about care provide to Mrs XXX XXX by Eastcare Residential Home (Kaylex Care Limited).

The complaint related to but was not limited to the following Health and Disability Services (Core) Standards (HDSS):

- HDSS 1.1 Consumer Rights
- HDSS 1.2 Organisational Management
- HDSS 1.3 Continuum of Service Delivery
- HDSS 1.4 Safe and Appropriate Environment

Relevant Information

On 16 May 2009 XXX XXX, a resident of Eastcare Residential Home, was allegedly taken in a car by three caregivers to the Victoria Central Accident & Medical (A&M) after-hours medical centre after she was found in an unresponsive state. The caregivers said they found Mrs XXX unresponsive about 7am. They arrived at the medical centre about 8.30am. XXX XXX stated that Mrs XXX was unresponsive, had hypothermia with a temperature of 31.3 degrees and had a Glasgow Coma Score (GCS) of 7. After examination, Mrs XXX was transferred to Waikato Hospital about 9am.

The complainant felt that the story did not match the caregivers account, for example why did Mrs XXX have hypothermia and why was there a need to take clothes off and dress her instead of calling an ambulance. It required 3 caregivers from the rest home and one healthcare assistant from the Medical Centre to assist in getting Mrs XXX inside the medical centre.

The A&M doctor also thought there was some evidence of a neck of femur fracture on XXX XXX's left side - which was not mentioned by the caregiver, as XXX XXX groaned when her left side was moved.

The doctor felt that it was possible the Mrs XXX had fallen due to a stroke - and that given her temperature she had been in her state for some time.

Inspection in relation to specific complaint

A HealthCERT Advisor and Team leader carried out an inspection of services provided at Eastcare Residential Home under sections 40, 42 and 43 of the Act to determine whether the services were being provided in compliance with section 9 of the Act.

Eastcare Residential Home is a Rest home and dementia unit. At the time of inspection the resthome had 14 residents and the dementia annex had 27 residents.

Mrs XXX XXX, aged 96, was transferred on 28 January 2009 from Tревеллн Rest Home in Hamilton with advanced dementia. Mrs XXX became a resident in the dementia annex at Eastcare Resthome and was assigned room 48.

Assessment by mental Health services for older people

Prior to her transfer to Eastcare Residential Home a Waikato DHB Health of Older Peoples mental health assessment of Mrs XXX was undertaken while Mrs XXX was resident in the Henry Rongomau Bennett Centre from 19 January to 28 January 2009. The assessment identified Mrs XXX's wandering was managed within the ward by orientation to room; she was cooperative with personal hygiene and eating and drinking well; calm and not requiring medication on a regular basis. She was unsteady and at high risk of falling.

Mrs XXX was noted to have a sleeping and settling pattern that altered between being up for the toilet a number of times through the night requiring oversight and assistance and direction back to bed, and sleeping well getting up only once for the toilet. It was also noted that "due to her cognitive deficit she has no insight and as a result poor judgement, requiring observation and monitoring at all times".

Assessment on admission to Eastcare Residential Home

Mrs XXX was assessed as having a high risk of falls on admission to Eastcare Residential Home. An assessment of Mrs XXX's activities of daily living was carried out with input from her daughter. The assessment included that Mrs. XXX was generally disorientated to time and place, her mood was described as euthymic (in the "normal" range, which implies the absence of depressed or elevated mood); Mrs. XXX was noted to be independent with toileting "with direction" and in need of assistance regarding weather appropriate clothing. A completed checklist for assessment of patient handling noted that Mrs XXX "sometimes required assistance" with transfers on and off the toilet, in and out of bed, chairs and with standing. Additionally Mrs XXX required assistance with showering and it was noted in the assessment of risk form that staff should ensure adequate lighting and no obstructions were in her way when up.

Mrs XXX was reviewed by Dr XXX the GP (29 January 2009) and Clonazepam 0.5mg (1/2 to 1 tablet PRN) was charted as PRN medication.

Ongoing assessment and care

Risk was reassessed 3 months after admission and reported as "risk remains the same". A care plan titled Poor Mobility/Prone to Falls had one up date on 13 April 2009 - "No falls reported. But a few bruises on her hands and currently on her chin due to her bending forward and bumping chin". A care plan titled At Risk Behaviors/Prone to Wander had an

entry on 30 April 2009 documenting that Mrs XXX had been seen by the GP and “commenced on Risperidone (0.5mgs daily) for restlessness”¹. On 6 May 2009 an entry on Mrs XXX’s behavior chart stated “XXX confused Hallucinating picking at unseen things”. The intervention was to administer clonazepam (? dose) and put to bed. The communication book entry for Mrs XXX on 14 May 2009 is as follows: “XXX XXX What is happening to her meds. Is she getting them?? Big gaps in signing for it! Unacceptable!!!”.

On 14 May 2009 the progress report entry records Mrs XXX was seen by the GP and commenced on antibiotics for “bronchitis”. Mrs XXX was also commenced on Pholcodine forte 5mls (PRN QQH) “for cough”. That evening (14 May 2009) Mrs XXX was noticed to be hallucinating and confused and was given Clonazepam 0.5mgs to settle. She was also given Pholcodine 7.5mls at 17.30hrs. On 16 May 2009 the progress report entry for Mrs XXX records that she was given Pholcodine 7.5mls at 12.00 and Clonazepam (1/2) at 12.30 (am).

On 17 May 2009 Mrs XXX was found on her bedroom floor at 12.50am and at 2.20am was found “sitting on the edge of her bed attempting to mobilise again” she was given Clonazepam (1 tablet) “to settle”. The next entry in the progress report notes that Mrs. XXX was “sent to hospital at 8am”. She “was unable to stand up in the morning for cares. Was very floppy and pale”. The carers noted that the registered nurse was aware and blood pressure and pulse recordings made B/P 99/66; pulse 56 and temperature 31.3. The progress notes state that XXX (registered nurse) “aware” and family “aware”.

Accident/Incident Forms

Accident forms were completed for 13 May when Mrs XXX was found to have a bruise of unknown origin on her buttocks; in 16 May when she was found on the floor with no physical injuries and on 17 May when Mrs XXX was again found on the floor with possible bruising to the left shoulder.

Staff qualifications

A review of the roster for the night commencing 16 May 2009 identified that one caregiver had a current first aid certificate and one caregiver had a certificate or unit standard in dementia care. Staff interviewed stated that they understood the concept of clinical restraint.

Information from staff interview

A caregiver interviewed reported that she knew XXX XXX who was “abusive, loud and aggressive but lovely underneath.” The caregiver who worked in the mornings said that Mrs XXX got up early and was usually up and dressed with others. Further because of her behavioural issues she may sometimes have gone to bed in her clothes. The caregiver said Mrs XXX was continent and when she went to bed she slept so may not have been checked on during the night.

¹ A documented precaution with the use of Risperidone is postural hypotension or sudden fall in blood pressure when a person stands up. Symptoms include dizziness, lightheadedness or temporary loss of consciousness.

The caregiver said that the facility used washable incontinence pants; there are no incontinence products and no pull ups. At night only kylies are used – residents lie on the kylie with a nightgown only. There are 2hourly toileting rounds so residents are changed 2hourly if toileting unsuccessful. The caregiver also noted that “night staff have a high workload, every one is up and dressed by 8.30am so must be doing the rounds early”. The night policy identifies that residents who are up and wandering early may be washed and dressed to keep warm and that residents generally start rising at approximately 6am.

The Manager, XXX XXX said that residents are checked hourly at night “to ensure they are comfortable and if they require attention”. However Eastcare Residential Home’s night policy clearly states that “care assistants perform toileting rounds once or twice a night depending on individual need”.

The registered nurse stated that she called between 7 and 8am (17 May 2009) regarding Mrs XXX, that she advised the family that Mrs XXX was not responding as usual but could talk. The registered nurse asked the family to take Mrs XXX to A&M but the family asked if the staff could take her. The night staff advised they would take Mrs XXX to the A&M on their way home. The registered nurse did not advise that 3 staff members went with her. The registered nurse said that an example of when an ambulance would be called instead of family or staff transporting residents was in circumstances where a fracture was suspected. The registered nurse said she was always available to provide telephone assistance, that she did not go on site as that was considered overtime (advised of this at time of employment) regardless of severity.

Physical environment

At the time of inspection there was a single small scope heater only in each bedroom room and in each corridor, (one heater per approximately 7 to 11 metres of corridor). Heaters were turned off and rooms and corridors cold. Heaters in the bedrooms room in the dementia unit (and in the room previously occupied by Mrs XXX) were partially obscured by large wardrobe units. The manager said that the dementia unit has a heat pump that is controlled by staff. The manager also said that the residents have freedom of choice in managing heaters in their rooms and communal areas. Further that independence is encouraged and residents can choose what they wish to wear which may be light clothing. However, this statement does not recognise the progressive nature of dementia.

Curtains in many bedrooms were in very poor condition with thermal liners ripped leaving a very thin window covering.

Conclusion

The complaint relating to Mrs XXX’s state on arrival at the A&M concerned her hypothermia, that she was non responsive (GCS 7) when found at 7am but fully clothed at 8am, that caregivers had transported her in this condition. The doctor felt that given her temperature Mrs XXX may have been in her state for some time.

The progress report entry for 17 May 2009 records that Mrs XXX was sent to hospital at 08.00 hrs having been unable to stand up in the morning and was very floppy and pale. There is documented evidence that Mrs XXX was seen at 12.50am and again at 2.20am. There are no further written reports about her until 08.00. The recorded period of time that

Mrs XXX was unattended was 4hours 40 minutes. There is no report of toileting or incontinence at either time. There is no report that Mrs XXX was found out of bed or on the floor after 2.20am. The caregiver interviewed said Mrs XXX may have gone to bed in her clothes because of "behavioral issues". Mrs XXX may have been inadequately clothed or covered during the length of time she was unattended. At the time of the inspection the corridors and rooms were cold. The curtains on the windows were thin and in poor condition. The progress note entry for 17 May 2009 states that Mrs XXX was unable to stand up in the morning and was very floppy and pale. Her temperature was recorded as 31.3. Mrs XXX was hypothermic prior to leaving Eastcare Residential Home.

Information obtained during the inspection identifies that Mrs XXX was found on the floor at 12.50 am and out of bed again at 2.20am on 17 May 2009. Mrs XXX was given Clonazepam 0.5mg at 2.20am. There is no documentation in careplans that identifies Mrs XXX's change in health status. There is no documented evidence that Mrs XXX received Clonazepam as a PRN medication prior to 14 May 2009 but there is a record in the communication book identifying that Mrs XXX's PRN medications were not regularly signed for. There was documented evidence that Mrs XXX was receiving Risperidone 0.5mgs daily from 29 January 2009 and Pholcodine 7.5mls PRN from 11 May 2009. Caregivers stated that they understood the concept of chemical restraint. In the progress report entry (for 17-5-09, 7-3) Mrs XXX was reportedly unable to stand up in the morning and was very floppy and pale. Her level of consciousness was clearly impaired prior to leaving Eastcare Residential Home Resthome and her inability to stand was not identified by caregivers as related to possible hip fracture. A staff report received following the draft inspection report states that Mrs XXX was conversant and able to assist with mobility when she left the home, however she deteriorated during transport. This report is inconsistent with the progress report contained in Mrs XXX's records and viewed at the time of the inspection. The staff report received following the draft inspection report also states that only one caregiver accompanied Mrs XXX.

It is unclear why an ambulance was not called. Given Mrs XXX's state, an assessment by a registered nurse was required. However, the registered nurse did not attend to assess Mrs XXX when caregivers reported her unresponsive and floppy. The registered nurse said that attending in person was not part of her job description and her job description states that she is "to be available to staff after hours for telephone advice and support, relating to residents care and needs." It was inappropriate for Mrs XXX to be transported in a caregivers care given her physical state as reported to the Registered Nurse prior to transport.

Summary of Inspection findings

Summary of findings where non-compliance to the Health and Disability Services Standards has been identified specific to the complaint and inspection. As previously noted, the scope of the inspection was widened in response to the tour of the facility and interviews with staff.

Consumer Rights during Service Delivery - Standard 1.1

1.1.3; 1.1.8; 1.1.9; 1.1.10 – Partial attainment

In the shared double room there was not privacy provided for use of the commode etc., Treatment protocols and procedures should be based on evidence-based rationales, which

are monitored and evaluated. Areas lacking evidence-based rationales were: infection control, wound care, medicine management and appropriate staff mix. Evidence was found of communal usage of creams and oils for skin care, all wounds were treated with dry wound healing, (refer 1. 1.3.12 for medicines, and 1. 1.2.8 for staff mix). Notation was limited in residents records of family involvement after admission.

Organisational Management - Standard 1.2

1.2.1; 1.2.2; 1.2.3; 1.2.4; 1.2.7; 1.2.8– Partial attainment

There was not a complete record of incidents and accidents held for the resident who was the subject of the complaint. There had not been analysis of recorded incidents and accidents to identify trends to inform quality improvement either at an individual or whole of service level.

There is collation of incident and accident reports. This does not formally include analysis against trends associated with individual residents or documented action plans to contribute towards improvement or avoidance of recurrences.

From interview with the manager: In the dementia unit residents are often found on the floor (? Lying down or having fallen). A form is always filled out, injury or no injury. An analysis is undertaken by the manager each month that records numbers and types of accidents.

The manager reported that the health and safety meeting involved the two registered nurses plus a caregiver who analyse the findings. Findings are then taken to staff meetings and discussed, rates for the month are compared to make staff aware of increases in risks. Care plans are updated three monthly. From review of documents: Only those accidents considered major are reported to next of kin, minor accidents not reported. There is no evidence of analysis of accidents translating in to change in care plans and incident forms are kept separate from files. Therefore there is no opportunity to review number of incidents over time per resident. There was no evidence that numerous falls resulted in any change in care or that numerous falls for a resident were recorded in their records. Events recorded, no closure of loop and no quality improvement for person. Accident report forms identify that family is not always contacted as staff define the level – minor or major- and notify only major. There is not a documented link between the quality management system and exception reporting process. There is no documentation of corrective action planning or a close out process where corrective actions have occurred or process for ongoing monitoring of implementation of improvements

A quality plan exists which includes developing staff knowledge and skills and excellence of service and understanding needs of elderly. The plan does not identify Quality Improvement but rather represents best practice. While there is a requirement for review and evaluation of care plans there is limited evidence in the resident's records. The Quality plan was reviewed in April 2009 and found to be meeting provider's philosophy. An emergency management plan exists.

Contenance management:- There was scant evidence of continence assessment in the files reviewed and no evidence of updated assessments. Eastcare Residential Home forwarded a copy of its Carers Continence Assessment Form; however of the 10 files reviewed none contained either a blank or completed form. A small number of disposable pads was viewed

in the store cupboard. There were numerous reusable continence pants, labelled, in the toilet areas. There was no evidence of wrap arounds or pull-ups (Nocte management). Lack of incontinence products: recyclable incontinence products were used- very few disposable products and at night anecdotally only Kylies used. The owner has a 2hrly toileting policy which includes a no products use at night. Reuseable pants may be used for other residents and staff noted that elastic is often broken. A single small disposable pad per day is not sufficient for all residents. While the manager stated that clients suffering from incontinence are allocated disposable products this was not supported by inspection or staff interview. Residents who have wet beds at night and do not have incontinence products will have to get up and have entire bedding and night attire changed often including in winter with possible poor heating.

Medication:- There were (communal) containers of zinc and castor oil and bottles of oil on the treatment trolley and in showers. There were unlabelled prescription medicines, and opened eye drops without an expiry date present, in the medication room/ trolley. Respite residents' medication was loose and not bubble packed as per other medications. PRN medications were not labelled for individual residents, and some medications were held back from being destroyed to be used for PRN medicines.

Staffing:- Low staffing for size of facility, dementia unit not always staffed with competent staff (there are staff without dementia training)

Cleaning:- Care staff do much of the cleaning and laundry.

Maintenance:- Many areas were shabby with evidence of water leak in Rest Home bathrooms/toilet, gaps around line in kitchen, carpet in Rest Home area needs replacing (stained and strong urine smell), Curtains thin and falling to bits and bed covers were of poor quality and torn or frayed.

While there as monitoring of some aspects of quality e.g. accident incident/ infection, collection of data and analysis there was no evidence of closure of quality loop with corrective action planning and evaluation.

Assessment / Continence Management/ Pain Management/ Fall Management / Infection Control do not follow current best practice. Evidenced by:-

- Assessments being incomplete or missing required components of assessment.
- Care plans being insufficient to demonstrate how the needs of residents will be met.
- Observation, clinical file, policy review and staff interview.
- Washable continence products being used, with no night product usage.

There was evidence of an internal audit system having been implemented in the last twelve months, however no follow through with corrective action plans and evaluation.

There was no evidence of internal audits to monitor compliance with the standards encompassing a corrective action plan and evaluation of the action leading to an outcome.

The registered nurse stated that she did not have a role in corrective action planning of incident and accident forms, this was carried out by the Nurse/Manager.

There is an orientation programme for new staff. This includes a buddy system and some competence checking by the registered nurse. An ACE training programme is used, but due

to registered nurse staff availability this has not been, activated recently. Therefore staff have not been able to complete or commence training. This has resulted in staff working in the dementia unit without adequate training.

There are two RNs who work 5 days a week, one is the manager. At the time of the inspection there were two care givers in each of the stage two rest home and the dementia annex. – total number of 46 residents. There was a Diversional therapist (DT) who worked from 8.30 to 11.30am. She had no DT qualifications. Advised that another DT worked 3 hours in the afternoon. There were two cooks, and a part time cleaner.

There are 7 care staff who hold a certificate or unit standard in dementia care. There is 1 staff recorded as currently undertaking dementia unit standard training, 5 of these care staff are regularly rostered to the dementia unit. There are shifts in the dementia unit where care givers are rostered without a dementia qualified care giver. One of the night care givers rostered regularly in the dementia unit is not qualified as a dementia care giver and is not undertaking dementia training.

The rest home regularly rosters 2 staff to a morning shift with a registered nurse Monday – Friday and a senior care giver Sat-Sun. Where the registered nurse does not take a resident allocation this results in a 1:15 ratio of care giving staff to residents. The rest home regularly rosters 2 afternoon shift and 2 night staff. The Dementia annex rosters 2 afternoon staff and 1 night staff.

There was one cleaner for the whole facility who works 3 hours Monday to Friday, care staff carry out the remainder of the cleaning.

The manager's office and staff office with resident's records/files was all outside the locked part of the facility in the entrance.

Continuum of Service Delivery - Standard 1.3

1.3.3; 1.3.4; 1.3.5; 1.3.6; 1.3.8; 1.3.9; 1.3.12; 1.3.13 – Partial attainment

Assessment and care planning is minimal and does not appear to involve family or to guide care or reflect updated conditions in many cases. Progress notes are intermittently completed with very brief entries, and the use of a non integrated communication book conveys resident information between shifts. Goals and evaluation of same for each resident are not clear. There was no documented evidence of family involvement in the development of care plans in the files reviewed.

Assessment and other documentation on admission is done with input from family addressing needs. However, this is not regularly updated. Documented assessment occurs on admission using a limited range of assessment tools. There is no documented assessment process for resident's in the event that their condition changes. Goals are not documented within the care planning.

Goals are not set. The relationship between the assessment and planning is not clearly demonstrated in documentation. For example a higher risk of falls did not correspond with a goal to prevent falls and associated interventions. Incident records were kept separately from the clinical file and not correlated at any point.

Several residents had obvious skin tears and haematomas on their legs, there was no evidence of shin protectors in use, or hip protectors and fall alarm mats. The manager stated that hip protectors were not used due to the confusional state and incontinence of the residents.

Incident and accident forms have a space for recording the notification of the event to relatives – this was not always completed in forms reviewed. Nursing assessments are not documented. Wound care planning is incomplete and does not represent a thorough wound assessment or planning process.

Where residents had sustained falls there was no recording of vital signs or documentation of an assessment. There was some evidence of discussion with families as recorded in progress notes. This was often in response to an incident or accident. There are no multidisciplinary or family meetings held by the facility.

There was some evidence of short term care plan use. Short term care plans do not include setting goals with the client for the resolution of the short term need. Short term care plans are not always used where indicated. For example where the resident has a wound, or challenging behaviour.

Long term care plans were not updated to reflect short term needs. Where a resident has had a fall and this has been recorded in the incident and accident record, there is often reference to 'checked by the RN'. There is not an associated documented assessment by the RN. There are insufficient records of monitoring where a resident's condition has changed or where progress against a treatment has been recorded. For example:

- The nurses handover/communication book has been used to record clinical information about residents with no associated documented assessments, change to care plans or introduction of a short term care plans.
- Where a resident had clearly had a change in continence status since admission, there was no continence assessment.

There is a hand over process between shifts. There is continuity of rostering across the facility. Interventions are brief and do not reflect the needs of residents in a sample of files reviewed. For example:

- Grooming – assistance
- Shower – alternate days
- Dressing - assistance

No evident involvement of greater interdisciplinary team apart from the GP who visits on a regular basis and documents well.

No evidence of NASC reassessment requests in 9 of the 10 files reviewed. A sample of progress notes reviewed indicates that care plans are not adequately reflecting the needs of residents.

In records reviewed, evaluations were briefly recorded against each aspect of the care plan. Evaluations did not occur against goals. Where a change in need of a resident was evident in progress notes there was not an associated short term care plan and evaluation of the effectiveness of the plan documented. GP review 18/6/09 noted weight loss of 5kg over 4

months. No recognition of this by RN or caregivers, no information in file re eating or other possible cause of weight loss – type 2 diabetic – no information on dietary needs, notes identify wandering. High risk score on Waterlow .

There were rest home residents identified through this investigation where the needs of the resident were likely to be dementia services. These residents had not been identified and had not been referred for a needs assessment.

Medication management:-

- Facility uses Medico pack system.
- Inspection of drug trolley found one medicine out of date(nitro lingual),
- Medications for respite residents were loose and not contained in blister packs and not all were labelled on individual container.
- PRN medications are not bubble packed, or specific to residents i.e. inhalers .
- Numerous unnamed medications found identified by RN as PRN
- Small basket containing unnamed inhalers.
- No CDs kept on site – any palliative care patients transferred.
- Medication reviewed by GP every three months and this is evidenced in the resident's files.
- No pharmacist review and pharmacist has not visited in past 1 – 2 years.
- Large tub of zinc and castor oil used communally and jars of oil for pressure skin cares.
- Some medications were held back from being destroyed to be used for PRN medicines.
- There were unlabelled prescription medicines and opened eye drops without the indication of an expiry date present in the medication room/ trolley

Nutrition, safe food and fluid management:-

- The kitchen was very small for its purpose and flies were present, there was an electronic insect destroyer in the kitchen.
- The floor and workspaces and windows were dirty and the staff used a hook beside the pantry and clean area to hang outer clothing.
- Dry foods were stored in sealed containers but there was no labelling or dating of the containers.

Safe and Appropriate Environment - Standard 1.4

1.4.2.3, 1.4.6; 1.4.7; 1.4.8 – Partial attainment

The facility was cold and there appeared little temperature control via heating for a cold winter day, frail residents were dressed in light clothing. All resident rooms and halls had skope heating in them but all except a few were turned off. The manager stated that it was likely that a resident walked around and turned these off. Shower areas were heated only by a heat lamp, old wall heaters were non functional. Cleaning was observed not to be of an acceptable standard. Floors and carpets were visibly dirty, Black mould was visible on windows. It was immediately noted that there was a strong smell of stale and fresh urine throughout the original facility.

The original part of the building was showing signs of deterioration and upon questioning the manager she stated that there is not a scheduled maintenance programme but there is a maintenance book where maintenance issues are identified that the owner/ or maintenance man acts on them. There had been discussion about possible renovation to occur in the future. A leak was noticed on the external wall of a toilet area, in zone three.

On inspection:

1. The Rest Home toilet areas had no hot water at hand basins.
2. Small scope heaters only in rooms and in corridors, one heater per 7 to 11 metres. Heaters turned off and rooms and corridors cold and dusty. Heaters in rooms in the dementia unit partially obscured by large wardrobe units.
3. Inadequate heating in bathrooms
4. Corridors along the south wall and by the laundry area dark.
5. Curtains in many bedrooms and those hanging on washing line in very poor condition with thermal liners ripped leaving a very thin window covering
6. Decor shabby with peeling paint in areas and mould growing on window sills. Many surfaces sticky.
7. In Dementia annex the room used to keep cleaning equipment does not have an adequate sump. Part time cleaners only, care givers do other cleaning.
8. Shower areas were heated only by a heat lamp, old wall heaters were non functional
9. Non-slip shower mats were in a poor condition and required replacement.
10. Water in the lounge toilet areas was cold, investigators ran the tap for several minutes after a resident complained of this
11. The laundry was clean and laundry was being managed within the dirty-clean flow areas, however there was no space for the folding of clean linen/clothing, this was carried out in the adjacent hall. Linen skips were uncovered.
12. There were washable kylie seat coverings on all resident/visitor lounge chairs, these chairs were mainly of an older type and not always suitable for the purpose. Staff stated these were necessary to keep the chairs in good order as there were so many incontinent residents and residents that had accidents or didn't make it to the toilet in time, although there was a strict 2 hourly toileting regime in place.

Although the facility has an RN on call, the registered nurse stated at interview that she did not attend when called as this was a part of her job description, and that if she came in this would ensue extra payment. Therefore she responded by phone and relied on the detail given to her by the care giver. There was no evidence of documentation or evaluation/follow up of these calls and the advice given. Excerpt from Registered Nurse Job Description "11.To be available to staff after hours for telephone advice and support, relating to residents care and needs."

Safe Restraint Practice - Standard 2.2

2.2.1 – Partial attainment

The main rest home area was fully locked, and residents/visitors required assistance or a key pad number to exit. All garden areas were enclosed within the facility. The manager stated that this was due to the facility being fully dementia/ mental health orientated, and that there were only a few residents who were able to leave the premises unattended.

Observation of clinical records showed that residents within the rest home had been assessed by NASC as stage 2 level care.

There were rest home residents identified through this investigation where the needs of the resident were likely to be dementia services. These residents had not been identified and had not been referred for a needs assessment.

Summation meeting

A summation meeting was attended by Marion McLauchlan, XXX XXX, XXX XXX and XXX XXX.

XXX thanked the facility for their participation and open 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 more information was required and photocopied information gathered needed further analysis. XXX noted that relatives interviewed had been complementary to the service, and that staff were very approachable. She confirmed that there would be findings against the Health and Disability Services Standards and these would be likely to include the following areas:

- Shortfall in appropriate care of residents associated with short staffing and lack of expertise
- Short staffing
- Quality and risk as incidents and accidents that have been reported have not been sufficiently analysed and quality improvements made and evaluated
- Lack of involvement by family in care planning
- Assessment on admission and thereafter
- Care planning where care plans do not adequately reflect the level of need particularly for dementia residents
- Lack of service integration
- Insufficient documentation within clinical records
- Continence management
- Pain Management
- Falls prevention
- Medicine Management
- Environmental – particularly the strong stale odour of urine throughout the rest home, XXX outlined that the odour was particularly bad in the original part of the building and the use of washable incontinence products and potentially incorrect product selection of disposable continence products for residents may also be contributing to the odour.
 - the low level of cleaning hours and the absence of monitoring/audit
 - heating of the facility.

The alleged complaint would be upheld in relation to:

- Assessment in the event of an accident including on-going monitoring of the resident's condition
- Transfer of a resident for medical consultation
- Falls prevention
- Pain assessment and management
- Appropriate referral to other services

There was also concern that there were residents whom require further assessment to determine whether they are appropriately placed in the facility. Residents in the rest home had identified as requiring dementia level care. Marion would be talking with the DHB/NASC about these residents.

XXX then outlined the process for receipt of the draft report and that the final report would be made available to the District Health Board. The meeting commenced at 3.30 pm and concluded at 4pm.

Conclusion

Kaylex Care Limited - Eastcare Residential Home will be required to take corrective actions to improve compliance against the Health and Disability Sector Standards. Ongoing monitoring will be undertaken by the Ministry of Health in conjunction with the District Health Board.

Report

A copy of HealthCERT's report is to be sent to the Waikato District Health Board.

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Appendix

Documents requested

- Staffing and skill mix policy
- Rosters (last month and this month)
- Abuse and Neglect Policy
- Management of Challenging Behaviour Policy
- Complaints management policy
- Complaints records for the last two months
- Clinical Assessment Tools in current use
- Staff orientation policy and process
- Staff training records and in-service training programme
- List of staff with current first aid certification
- List of staff with current medication competency
- Quality and risk management plan
- Emergency Response Policy
- Incident and accidents records for the last two months
- Minutes of staff meetings
- Minutes of quality meetings
- Resident files
- Completed resident satisfaction survey

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