Final Inspection Report

Summerset Care Limited-Summerset By The Park

Date of inspection: 16 July 2010

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HealthCERT
Provider Regulation
Population Health
Ministry of Health

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Undertaken	**16 July 2010**
File Ref:	**WSU14**
Provider:	**Summerset Care Limited**
Contact Person:	**XXX XXX, Village Manager**
Premise:	**Summerset By The Park** **7 Flat Bush Road** **Otara** **MANUKAU**

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Executive Summary

History:

Summerset by the Park has been in operation for a period of 14 months.

In May 2010 the CMDHB received 3 complaints from residents' families concerning care provided by Summerset By The Park, these complaints alleged that:

- poor wound care management
- poor food quality
- hygiene and rodent control issues
- laundry issues
- insufficient care and cleaning staff
- inadequate fire drills
- inappropriate falls management
- poor response time to call bells
- medication management

In early June 2010 in order to gain further insight into issues of concern received from various sources about the facility, Counties Manukau District Health Board (CMDHB), contracted the services of a monitor to visit the premises and report back to CMDHB findings obtained from those visits. Interviews were conducted at the facility by the monitor with residents, family/whanau and staff members. Each group was spoken to regarding their experiences in association with Summerset by the Park. Outcomes from interviews ranged from favourable to unfavourable comments in nature.

Emergent themes from resident family/whanau interviews were the unsatisfactory nutritional service, issues of poor staff hygiene practices, lengthy times taken by staff members to respond to call bells, poor follow-up or no follow-up on requests and a perceived lack of confidence and trust in the Nurse Manager by both residents family/whanau and staff alike.

Nature of Current Complaint:

The Ministry of Health has received a complaint from Mrs XXX through Counties Manukau District Health Board about the care provided to Mr XXX at Summerset Care Limited - Summerset By The Park.

In summary, the complaint alleges that:

- Nobody at Summerset realized that my husband was ill and only did something when his friend insisted. Who knows what would have been the outcome if nothing had been done.
- This is a large facility and it seems to be hopelessly understaffed.
- The staff are inadequately trained.
- Any time I have voiced concerns there is always an excuse.
- Compassion for the patients seems to be non existent.

Service Description

Summerset Care Limited – Summerset By The Park provides Aged Residential Care Hospital Services (Medical Services; Geriatric Services) & Rest Home Services. The occupancy and capacity is outlined below:

Area	Occupied	Capacity
Hospital	31	34
Rest Home	21	18
Dementia	0	0
Total	**52**	**52**

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Reasons for the inspection

The purpose of the inspection was to determine whether health care services being provided by Summerset Care Limited – Summerset By The Park are being provided in compliance with section 9, Health and Disability Services (Safety) Act 2001, 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:

(a) *'while certified by the Director-General to provide health care services of that kind; and*

(b) *While meeting all relevant service standards;*

(c) *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*

(d) *in compliance with this Act.'*

The inspection team

The inspection was undertaken by XXX XXX, Senior Advisor 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 Services Standards. Findings are according to the Health and Disability Services Standards NZS8134:2008.

The inspection was conducted utilising the following methods:

- Interview with Manager.
- Interview with Registered Nurse (Clinical Leader).
- Individual staff interviews.
- Resident interviews.
- Observation: During facility tours and observation of the facility.
- Observation: Residents and Staff.
- Document and policy review: See the appendix for a list of documents that were requested as part of the audit process.
- Clinical Notes review: A sample of residents' notes from the facility was audited.

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Limitations

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

Entry Meeting

The introduction meeting covered the following points:

A copy of the letter of introduction addressed to XXX XXX, Village Manager was provided to her at 8am on 16 July 2010.

A proposed agenda for the day was discussed included, an audit of requested documents and a request to interview residents, staff and any relatives or health professionals (GP) visiting the facility during the course of the day. The inspection commenced with a tour of the facility.

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 limited to the issues raised in the complaint.

Consumer Rights during Service Delivery - Standard 1.1

1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

– Partial attainment Low 6 Months

Policy and procedure in place, Staff education had been carried out.

Forms were outside nurses station.

Meeting minutes were limited in respect of complaints and their outcomes/quality improvements.

Corrective Actions:

Ensure that staff are informed regarding complaints and their outcomes/ quality improvements and that corrective actions are developed and implemented.

1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken

– Partial attainment Low 6 Months

No all known complaints were listed within the register, staff tend to deal "on the spot" with complaints and not document them.

Of the complaints listed there is no corrective action or evaluation of outcomes documented

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Corrective Actions:

Ensure that all complaints are documented and that staff training on complaints management is undertaken.

Organisational Management - Standard 1.2

1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.

– Partial attainment Moderate 3 Months

Summerset policy and procedures are developed, however management and staff are not always following policy and process. Such as:

- Managing unwell residents procedures, adverse events not followed
- Customer complaints policy not followed

Corrective Actions:

Ensure that staff training about the quality and risk management system is undertaken and that policies and processes are complied with.

1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.

– Partial attainment Moderate 3 Months

Meeting minutes have limited feedback for informing staff re incidents accidents and their outcomes and quality improvements.

Not all incidents/accidents are documented on the correct form.

Hazards, incidents and infection registers were evidenced as not accurate.

Corrective Actions:

Ensure that staff training on the quality and risk management system is undertaken and that policy and processes are complied with.

1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

– Partial attainment Low 6 Months

Summerset have a policy and procedure about internal auditing in place for this criteria to be met. However, the Manager and staff do not always comply, and there was limited evidence of corrective actions being developed and implemented.

Corrective Actions:

Develop and implement corrective action plans.

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1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk.

(b) A process that addresses/treats the risks.

– Partial attainment Moderate 3 Months

Information management, clinical files were not integrated.

Current health or disability status not always updated for residents needs.

Specific risk assessment tools not used correctly or at all for residents with changing needs.

There was evidence of limited multidisciplinary input and specialist advice was not evidenced as being acted on.

Systems of effective communication not evident.

Hazards, incidents and infection registers were not accurate.

Corrective Actions:

Ensure that staff training on the quality and risk management system is undertaken and that policy is complied with.

1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

– Partial attainment Moderate 3 Months

Documentation of complaints, incident/accidents was not always carried out.

Meeting minutes contained limited feedback for informing staff re complaints, incidents / accidents and their outcomes/ quality improvements.

Corrective Actions:

Ensure that staff training on adverse, unplanned, or untoward events including service shortfalls is undertaken and that policy is complied with.

1.2.4.4 Adverse, unplanned, and untoward events are addressed in an open manner through an open disclosure policy.

– Partial attainment Low 6 Months

Residents and where appropriate family/whanau are not always informed concerning adverse events.

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Corrective Actions:

Ensure that staff training on open disclosure is undertaken and that policy is complied with.

1.2.9.10 All records pertaining to individual consumer service delivery are integrated.

– Partial attainment Moderate 3 Months

Resident recordings filed in separate files, eg B/P, weight, fluid balance.

Integration of residents files was not evidenced, caregivers write in one set of progress notes which are reviewed weekly by an Registered Nurse (RN) and the RNs write in another set of progress notes, one resident (from a sample of 9) was found to have 3 sets of progress notes in place.

Individual clinical records were not kept in a consistent format.

Corrective Actions:

Ensure that all records pertaining to individual consumer service delivery are integrated

Continuum of Service Delivery - Standard 1.3

1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

– Partial attainment High 1 Month

Summerset policies and procedures are in place, however policy was not consistently followed for Respite residents or long term residents.

Corrective Actions:

Ensure that entry criteria, assessment, and entry screening processes are undertaken and that policy is complied with.

1.3.3.3 Each stage of service provision (review, and exit) is provided within time frames that safely meet the needs of the consumer.

– Partial attainment High 1 Month

Respite residents did not always have care plans developed or updated.

Respite residents were not always seen by a GP within the required timeframe post admission.

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Corrective Actions:

Ensure that all residents receive service provision within time frames that safely meet their needs.

1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

– Partial attainment High 1 Month

Summerset policies and procedures are in place but not always followed by manager and staff.

There was not evidence of consistent use of assessment tools, short term care plans or re-evaluation, such as:

- Falls risk – a separate falls risk assessment was not always completed where relevant, frequent fallers files had no evidence of post fall assessments.
- A resident with a red sacral area had had no Pressure Area Care assessment.
- Not all residents are examined by a GP within 2 working days of admission (ARRCS Agreement D 16.5 e [i]).
- Residents known to have pain had no pain assessments.
- A resident with challenging behaviour had not had any behaviour assessment.

In regard to the complaint:

- RN manager stated the resident was alert day of admission, RN Manager made no documentation of any assessment.
- There was only one documented entry from an RN on the day the resident was admitted to hospital during 27may -1 June admission.
- 1/6/10 RN progress notes showed the resident was weak and coughing. No respirations taken or oxygen saturation levels but other observations were done.
- There were no RN progress notes leading up to the 1/6/10 and care giver documentation indicates the resident to be alert and communicative – states 1/6/10 "went to the doctor before lunch – GP called ambulance".
- The resident had no GP assessment on admission.

Corrective Actions:

Ensure that RN complete assessments of all residents admitted, and that policy is complied with.

Ensure that GP reviews are completed as per the ARRCS Agreement.

1.3.5.1 Service delivery plans are individualised, accurate, and up to date.

– Partial attainment Moderate 3 Months

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Summerset policies and procedures are in place, but were not being followed by manager and staff.

Respite residents files reviewed did not evidence of fully developed care plans.

Multidisciplinary involvement in care plans was not evidenced.

There was limited documented involvement of family in the care plans.

In regard to the complaint:

No falls risk assessment completed and the old care plan from the resident's March admission used for the May admission.

No date on initial care and support plan and this plan did not relate to the May admission.

No evidence of RN assessment.

Corrective Actions:

Ensure that care delivery plans are individualised, accurate and up to date.

1.3.5.3 Service delivery plans demonstrate service integration.

– Partial attainment Moderate 3 Months

Evidenced that visiting Specialist Nurses and GP requests were not followed, eg, no behaviour monitoring for a resident with challenging behaviour, no blood pressure recordings monitored, no TED stockings fitted, fluid balance charts not kept up to date.

Corrective Actions:

Ensure that care delivery plans are recorded in a consistent format and demonstrate service integration.

1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

– Partial attainment Moderate 3 Months

Changes in residents progress was not reflected in the care plans.

Tracer methodology showed that:

- falls were noted in one of the progress notes but no re assessment or change to care plan was made
- short term care plans for wound care following skin tears were not developed, and no changes were made to the care plans following instructions in care from GP or visiting nurse specialists.

Corrective Actions:

Ensure that care delivery plans are accurate and up to date.

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Summation meeting

A summation meeting was attended by XXX XXX, Senior Advisor HealthCERT and XXX XXX, Senior Advisor HealthCERT, XXXXXX, Village Manager and via conference telephone call, XXX XXX, National Clinical manager and XXX XXX, Area Manager.

XXX thanked the facility for their participation and approach to the investigation recognising that this was an unannounced inspection. XXX noted that residents interviewed had been complementary to the service, and that staff were approachable. She confirmed that there would be findings against the Health and Disability Services Standards, and that the complaint would be substantiated.

Key issues raised at summation were:

1. Relevant to complaint:

Complaint management:

Not always documented, of those documented there was no evaluation of outcome or feedback to staff, the register was not complete with all known complaints, corrective actions were not documented or addressed.

Staff Availability:

Currently satisfactory, however records showed that at the time of the complaint there was staff shortages and high resident acuity reported.

Assessment:

Manager and staff not implementing service delivery policies fully:

- Lack of consistent use of clinical assessment tools as per policy.
- Due to lack of assessment no short term care plans or evaluations were completed.
- No assessment of respite care residents by GP.

Care Planning:

- Limited involvement of family/whanau documented in care plans.
- Respite residents not having fully developed care plans (residents insitu over 3 weeks).
- Lack of multidisciplinary input into care plans (sort but not connected into plans).
- Progress notes/adverse events not linking into care plan changes or short term care plans.

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Evaluation:

- Limited evidence of ongoing evaluation in either progress notes or care plans.

2. Not relevant to complaint:

Staff education regarding challenging behaviour.

Medication, 3 monthly GP reviews.

No Hand Rails evidenced in corridors.

Conclusion

Summerset Care Limited – Summerset by the Park will be required to take the above corrective actions to improve compliance against the Health and Disability Services Standards. On-going monitoring will be undertaken by the Ministry of Health in conjunction with the District Health Board.

The complaint about the healthcare services provided by the Summerset Care Limited, which alleged that:

- Nobody at Summerset realized that my husband was ill and only did something when his friend insisted. Who knows what would be been the outcome if nothing had been done.
- This is a large facility and it seems to be hopelessly understaffed.
- The staff are inadequately trained.
- Any time I have voiced concerns there is always an excuse.
- Compassion for the patients seems to be non existent.

The complaint was found to be substantiated with the exception of the last point:

- compassion for the patients seeming to be non existent.

Additional Conditions

Additional conditions to be placed on the Certification Schedule:

1. A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards: 1.3.1.4; 1.3.3.3; 1.3.4.2; as identified in the Inspection Report must be submitted to the Director-General by 30 September 2010.

2. A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards: 1.2.3.1; 1.2.3.5; 1.2.3.9; 1.2.4.3; 1.2.9.10; 1.3.5.1; 1.3.5.3; 1.3.8.3 as identified in the Inspection Report must be submitted to the Director-General by 30 November 2010.

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3. A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards: 1.1.13.1; 1.1.13.3; 1.2.3.8; 1.2.4.4 as identified in the Inspection Report must be submitted to the Director-General by 28 February 2011.

4. HealthCERT may elect to carry out a verification audit in relation to these corrective actions.

5. 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.

Summary for Publication

The Ministry of Health received a complaint in July 2010, concerning the care provided to a resident at Summerset Care Limited – Summerset By The Park.

The purpose of the unannounced inspection undertaken on 16 July 2010, was to determine whether health care services being provided by Summerset Care Limited are being provided in compliance with section 9, of the Health and Disability Services (Safety) Act 2001. That is a person providing health care services of any kind must do so whilst meeting all relevant standards.

There were findings against the Health and Disability Services Standards in regards to Consumer Rights, Organisational Management and Service Delivery.
Corrective actions are required to ensure:

Consumer Rights:

Staff are informed regarding complaints and the outcomes/quality improvements and that corrective actions are developed and implemented.

All complaints are documented and that staff training on complaints management is undertaken.

Organisational Management:

Staff training about the quality and risk management system; adverse, unplanned, or untoward events including service shortfalls; and open disclosure are undertaken and that policies and processes are complied with.

Develop and implement corrective action plans.

All records pertaining to individual consumer service delivery are integrated.

Continuum of Service Delivery:

Entry criteria, assessment, and entry screening processes are undertaken and that policy is complied with.

All residents receive service provision within time frames that safely meet their needs.

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Registered Nurses complete assessments of all residents admitted, and that policy is complied with.

General Practitioner resident reviews are completed.

Care delivery plans are individualised, accurate and up to date and recorded in a consistent format and demonstrate service integration.

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Appendix

Documents requested

- Staffing and skill mix policy
- Rosters (last month and this month)
- Abuse and Neglect Policy
- Complaints management policy
- Complaints records for the last two months
- 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
- Incident and accidents records for the last two months
- Minutes of staff meetings
- Minutes of quality meetings
- Resident files
- Completed resident satisfaction survey
- Hazard Register
- Internal Audit Plan and results of audits
- Medication Folder

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