Final Inspection Report

Elsdon Enterprises Limited

Annaliese Haven Rest Home

Date of Inspection:

10 February 2016

HealthCERT
Clinical leadership, Protection and Regulation
Provider Regulation
Ministry of Health

Table of Contents

1. Provider Details

Certificate:	Two years: 1 July 2014 – 1 July 2016
Premises:	Annaliese Haven Rest Home
Premises Address:	25 Adderley Terrace
Contact Person:	[redacted], Facility Manager
Inspection Date:	10 February 2016

2. Executive Summary

The Ministry of Health received information which alleged Elsdon Enterprises Limited could be in breach of its obligations as a certified provider under the Health and Disability Services Act (2001) to provide services at Annaliese Haven Rest Home.

On receipt of the information, the Canterbury District Health Board (DHB) contacted the Ministry to discuss the concerns raised. The concerns related to clinical care of residents, including accessing general practitioner services; incident reporting and staffing. A decision was made by the Ministry and DHB to undertake an unannounced inspection to assess aspects of the relevant Health and Disability Services Standards (2008).

The inspection was completed on 10 February 2016 at Annaliese Haven Rest Home. The inspection was completed by the Ministry in accordance with sections 40, 41, and 43 of the Act. Four clinicians from Canterbury DHB were also on the inspection team.

The focus of the inspection was to assess aspects of the quality and risk framework (including incident reporting) and staffing; and to determine if clinical care was being completed to the required standard. In addition the inspection team considered governance, complaint management, and aspects of consumer rights. The inspection team reviewed 11 resident clinical files, interviewed ten staff and a general practitioner; and, undertook conversations with residents and families.

On the basis of the evidence reviewed during the inspection, Annaliese Haven Rest Home did not fully comply with 12 of the Health and Disability Services Standards (NZS 8134:2008). The partially attained standards related to: complaints management, governance, quality and risk framework including incident reporting, human resource management, staffing, and, assessment and care planning.

Observations were made in respect of the activities programme, food services and reporting in clinical records.

Ongoing monitoring will be undertaken by Canterbury DHB.

3. Entry Meeting

On arrival at the premises, [redacted] and [redacted], Senior Advisors, HealthCERT, Ministry of Health, and the clinical team, met with [redacted] Facility Manager, [redacted], Clinical Nurse Manager and [redacted], Assistant Manager.

The purpose of the visit was explained and a letter addressed to [redacted] (Director) outlining aspects of the complaint and the authorisation to undertake the unannounced visit was given to [redacted] (Facility Manager). A copy of the Director-General of Health's delegation was shown to the [redacted] and it was explained how the inspection would be undertaken.

4. Background

Law:

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

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

Facts:

a) Governance

Elsdon Enterprises Limited - Annaliese Haven Rest Home is privately owned. Two Directors attended the closing meeting.

Annaliese Haven provides rest home and dementia level care for up to 63 residents. On the day of the inspection there were 19 rest home and 26 dementia residents, noting dementia care is provided in two units.

Annaliese Haven Rest Home is managed by a non-clinical facility manager (FM) who had been in post eight weeks at the time of the inspection. The FM reports to the Directors. The inspection team were informed there had been three changes of FM over the last two years. Clinical care is overseen by a full-time clinical nurse manager (CNM) (registered nurse) who works full time.

While meetings reportedly occurred between the FM and the Directors, there was no evidence to verify reporting between the two parties. In addition there was a Quality Plan outlining service goals, however this was dated 2015 and overdue for review (finding 1.2.1).

b) Quality and Risk Management Systems

There is a quality framework at Annaliese Haven that requires reinvigorating. Analysis of incidents has been undertaken (sighted November and December 2015 analysis), and staff meetings have reportedly recommenced (meeting minutes not sighted).

While there is a Quality Plan with objectives, this is overdue for review (refer finding 1.2.1) and the internal audit programme needs to be fully implemented. A resident satisfaction survey is to be undertaken (finding 1.2.3).

The complaint log/register was reviewed at Annaliese Haven and positively, it is noted there are very few complaints. The complaints log had a number of columns including (but

not limited to): Date and Date Actioned. Review of the log relating to a complaint received in October 2015 recorded the same date in both columns, however there was an email from the complainant post the recorded date, suggesting they had not received acknowledgement of their concerns. The acknowledgement process was unclear based on the information reviewed (finding 1.1.13). There was discussion with the provider around systematising the complaints log so that complaints are recorded in a chronological order and key aspects of the complaints process are recorded.

c) Adverse Event Reporting

There is an incident form that is available to report incidents, and staff interviewed were aware of the requirement to report resident incidents.

A review of 44 incident forms completed across November and December 2015 were reviewed and three areas of improvement relating to incident management were noted:

- 27 forms did not record that the resident's relative had been informed of the incident, this was verified by interview with relatives (finding 1.1.9)
- 14 of the incident forms reviewed did not include prevention strategies to minimise the recurrence of the incident (finding 1.2.4)
- In three resident files there were incidents recorded where an associated incident form could not be located on the day of inspection (finding 1.2.4)

Incident analysis had recommenced (sighted data November and December 2015) with the provider aggregating falls, resident behaviour and combined skin tears/bruising. Although not a requirement, there was discussion around the benefit of capturing pressure injuries through the event reporting programme, and analysing skin tears and bruising separately.

In addition to incident reporting at the facility level, the provider needs to be conversant with reporting particular events to the district health board and/or the Ministry of Health. To this end, on the day of the inspection, there was [redacted] resident being cared for in the dementia unit that was reportedly requiring [redacted]. In such circumstances, the Ministry of Health require the provider to apply for a dispensation in order that the resident remain in the dementia unit (finding 1.2.4).

d) Human Resource Management

Seven staff files were reviewed, and while it is evident there is an absence of required documentation in some instances; the FM was aware of the issue and there was evidence to confirm a process was being implemented to work through to resolve. It is noted police vetting is undertaken, however at the time of inspection there is reportedly a delay in receiving response from the police service. There was evidence that applications to the police service were being made in a timely manner. Performance appraisals are overdue for a number of staff (finding 1.2.7).

There was evidence of training having been provided to staff during 2015, and an education plan was available for 2016 with scheduled training seen to have occurred.

e) Service Provider Availability

On the day of inspection there were 45 residents at Annaliese Haven. There were a small number of residents who had increasing care needs - [redacted] in the dementia unit was reportedly [redacted] and [redacted] in the rest home were in the process of being reassessed. In addition, the inspection team identified [redacted] residents in the rest home whose care needs were increasing and [redacted] resident who may be better suited to a secure environment. While there is a roster available, there did not appear to be an adjustment to staffing levels to meet changing health needs of residents.

In addition the active roster recorded a registered nurse (RN) as being on duty, however interview informed the RN was on extended leave. This position was observed to have not been backfilled. This RN was responsible for completing InterRAI assessments at the facility – noting at the time of inspection only four had been completed (finding 1.3.4).

Relative interview suggested there were times when staffing was an issue (finding 1.2.8)

f) Clinical Documentation

Eleven resident files were reviewed across both service types. Although the InterRAI assessments were not current review of the long term care plans were underway. Interventions were mostly recorded in the progress notes (refer observation in respect of clinical records). There were a number of examples where assessments, care plans and documentation were not meeting the required standard. Some examples include:

- Initial assessment (nursing and medical) were not always completed within the required timeframes, and long term care plan reviews were not consistently completed six monthly (finding 1.3.3)

- Timely referral for reassessment of residents whose care needs change is to be addressed (finding 1.3.3)

- Assessments were not consistently undertaken to inform long term care plan development and updating (finding 1.3.4)

- Long term care plans were not always sufficiently comprehensive to clearly articulate resident needs (finding 1.3.5)

- Evaluation of goals, and short term care plans was inconsistent (finding 1.3.8)

- In two instances enduring power of attorney documentation and supporting documentation needs to be considered (finding 1.1.10)

g) Observations

The following are additional observations. It is noted there was insufficient time during the inspection to fully consider these aspects of service delivery in order to determine compliance with the relevant standard.

Activity Programmes: based on observation on the day of the inspection and, resident and relative interviews, there is the opportunity to review and enhance the activities programme offered. It is acknowledged on the day of the inspection the diversional therapist and/or activities coordinator were not interviewed.

Food Services: based on resident interview, food services would benefit from review (noting the finding against 1.2.3 re a resident satisfaction survey). It is acknowledged the provider informed food services were reviewed by a dietician in November 2015.

Clinical records: based on review of files there is the opportunity to strengthen clinical detail and frequency of entries recorded in the resident files across staff disciplines. In one file where an incident was recorded there was no documented follow up and in another there was an absence of regular registered nurse entries. One short term care plan had not been signed off by a registered nurse. In two files the general practitioner entry was reportedly brief.

5. Inspection Team

The inspection was undertaken by [redacted], Senior Advisor, HealthCERT, [redacted], Senior Advisor, HealthCERT, Ministry of Health, [redacted], Social Worker/Team Leader Older Persons Mental Health, [redacted], Registered Nurse Older Persons Mental Health, [redacted], Social Worker, Older Persons Mental Health and [redacted], Registered Nurse Clinical Assessor, Older Persons Health NorthEast Community Team, under delegated authority of the Director-General of Health.

6. Inspection Methodology

The following methodology was used during the inspection:

- Interview with staff, residents and relatives
- Observation of residents
- Physical inspection of premise / equipment
- Review of Clinical Records

7. Inspection Limitations

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

8. Inspection Findings

Findings have been reported against the following standards Health and Disability Services Standards NZS 8134.1:2008

Relevant Standard	Findings	Required Corrective Action	Rating and time frame.
Standard 1.1.9 Service providers communicate effectively with consumers and provide an environment conducive to	The service incident form includes a section to record family notification. 44 incident forms were reviewed across November and December (2015). 27 forms did not record that family notification had occurred. Interview with family members, and review of resident files informs family notification is not consistently	Family are notified following resident incidents	PA Moderate 60

Relevant Standard	Findings	Required Corrective Action	Rating and time frame.
effective communication	undertaken (and/or recorded in resident files) following an incident		
1.1.10 Informed Consent Consumers and where appropriate their family/whanau of choice are provided with the information they need to make informed choices and give informed consent.	Two of the six resident files reviewed in the dementia units identified EPOA documentation that required review - in one file the EPOA had not been activated and in the second, the resident had signed their own resuscitation forms	EPOA is implemented appropriately	PA Moderate 90
Standard 1.1.13 The right of the consumer to make a complaint is understood, respected, and upheld	A complaints log is maintained. The acknowledgement process was unclear based on the information reviewed on the date of inspection.	Complaints are acknowledged within appropriate timeframes and the complaint log reflects actions taken	PA Low 90
Standard 1.2.1 The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers	The service is managed by a non-clinical facility manager who had been in post eight weeks, and a clinical manager (registered nurse). While the facility manager has meetings with the owners of the service there were no minutes available on the date of the inspection. There is a quality plan (2015) in place that requires review.	Formalised reporting mechanisms between the facility manager and directors/s are established and recorded. The quality plan requires updating to reflect the goals for the current year	PA Moderate 90
Standard 1.2.3 The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles	There is a quality framework in place that requires reinvigorating (link finding 1.2.1). Analysis of incidents has recently commenced (sighted November and December 2015) along with staff meetings. The internal audit programme needs to be verified and implemented for the current year, and a resident satisfaction survey is to be undertaken.	Internal audits are completed as per the audit schedule and a resident satisfaction survey is to be undertaken	PA Moderate 90
Standard 1.2.4 All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where	44 incident forms were reviewed across November and December. 14 did not record prevention strategies post incident. In three resident files reviewed there were recorded incidents where an associated incident form could not be located on the day of inspection (link finding 1.1.9). On the day of inspection there was [redacted] resident in the dementia unit who was considered to be [redacted], the provider was	Resident incidents are reported on the relevant form, and reported incidents identify prevention strategies to minimise recurrence. The provider is aware of their obligation in respect of essential notifications	PA Moderate 60

Relevant Standard	Findings	Required Corrective Action	Rating and time frame.
appropriate their family/whānau of choice in an open manner	unaware of the requirement to seek a dispensation.		
Standard 1.2.7 Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	Seven staff files were reviewed, and while there are gaps in the documentation contained in the files it was evident the facility manager is aware of the issue and working to amend same. Staff appraisals are overdue.	Staff appraisals are completed annually	PA Low 90
Standard 1.2.8 Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	On the day of inspection there were 45 residents. [redacted] residents in the dementia unit was considered to [redacted] and [redacted] in the rest home were in the process of being reassessed due to increased care needs. In addition, there were [redacted] residents in the rest home whose care needs were increasing and [redacted] resident who may be better suited to a secure environment. Review of the roster did not indicate staffing levels were being adjusted to meet changing health needs of residents. In addition the active roster recorded a registered nurse as being on duty, however interview informed the RN was on extended leave. This position was observed to have not been backfilled. Relative interview suggested there were times when staffing was an issue.	Ensure the active roster accurately reflects day-to-day staffing, planned absence is backfilled and staffing levels are adjusted to meet resident need	PA Moderate 30
Standard 1.3.3 Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals	Review of files indicated initial assessment – nursing and medical, review of resident long term care plans and, referral to NASC for reassessment are not consistently undertaken in a timely manner. Note comment against 1.3.4 re InterRAI assessment.	Initial assessments (nursing and medical) are undertaken/recorded within prescribed timeframes. Review of long term care plans are completed six monthly. There is timely referral to NASC for reassessment when residents care needs change	PA Moderate 90
Standard 1.3.4 Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	Initial assessments are completed on admission (link finding 1.3.3), however these are not consistently reviewed six monthly in line with the long term care plan review, and/or if the residents health changes. Of the 45 residents in the service, four had completed InterRAI assessments.	Assessments are undertaken to inform the development of long term care plans and when the residents care needs change	PA Moderate 60
Standard 1.3.5 Consumers' service delivery	In the majority of files reviewed long term care plans had recently been updated (link 1.3.3 and 1.3.4). The	Care plans are sufficiently detailed to reflect resident care needs, and family are	PA Moderate 90

Relevant Standard	Findings	Required Corrective Action	Rating and time frame.
plans are consumer focused, integrated and promote continuity of service delivery.	long term care plans reviewed were not sufficiently detailed to support care provision. Interview with family members indicated they are not consistently involved in care plan review.	invited to be involved in care plan review	
Standard 1.3.8 Consumers' service delivery plans are evaluated in a comprehensive and timely manner	Long term care plan review was well underway, however there was limited evidence of evaluation of the previous goals set. Short term care plans were used for short term issues and wound plans in place for the five wounds at the facility. In two wound care plans progress following dressing change was not consistently recorded and evaluation of short term care plans was inconsistent	Evaluation of care is recorded	Low 90

9. Summation Meeting

Present: [redacted], Senior Advisor, HealthCERT, [redacted], Senior Advisor, HealthCERT, Ministry of Health, [redacted], Social Worker, Older Persons Mental Health and [redacted], Registered Nurse Clinical Assessor, Older Persons Health NorthEast Community Team, [redacted], Director, [redacted], Director, [redacted], Facility Manager, [redacted], Clinical Nurse Manager and [redacted], Assistant Manager, [redacted] Nursing Director, Older People, [redacted], Team Leader, Canterbury & West Coast District Health Boards Planning & Funding.

[redacted] thanked the facility for their participation and approach to the investigation recognising that this was an unannounced inspection. It was explained that a full summation of findings could not be provided at the closing meeting as information gathered needed further analysis. The provider was advised that this investigation report would be published on the Ministry of Health website.

The findings and observations in respect of the activity programme, food services and recording in clinical records were discussed at the summation meeting.

10. Conclusion

Under Section 9 of the Act, certified providers must meet all relevant standards and comply with any conditions subject to which the provider was certified by the Director-General of Health. Elsdon Enterprises Limited is required to undertake the following corrective actions within the specified timeframes. If the corrective actions are not achieved, the Ministry may take action in relation to non-compliance with the requirements of the Act.

Required Corrective Actions

A written progress report that outlines all actions undertaken by the provider in relation to the corrective measures required against Health and Disability Services Standard 1.2.8 (as approved under Section 13 of the Act) must be submitted to your District Health Board by 23 March 2016. Your District Health Board will inform the Director-General of Health of

progress in accordance with the Ministry of Health's requirements. An amended schedule will be issued if progress is not satisfactory.

A written progress report that outlines all actions undertaken by the provider in relation to the corrective measures required against Health and Disability Services Standard 1.1.9, 1.2.4 and 1.3.4 (as approved under Section 13 of the Act) must be submitted to your District Health Board by 23 April 2016. Your District Health Board will inform the Director-General of Health of progress in accordance with the Ministry of Health's requirements. An amended schedule will be issued if progress is not satisfactory.

A written progress reports that outlines all actions undertaken by the provider in relation to the corrective measures required against Health and Disability Services Standard 1.1.10, 1.1.13, 1.2.1, 1.2.3, 1.2.7, 1.3.3, 1.3.5 and 1.3.8 (as approved under Section 13 of the Act) must be submitted to your District Health Board by 23 May 2016. Your District Health Board will inform the Director-General of Health of progress in accordance with the Ministry of Health's requirements. An amended schedule will be issued if progress is not satisfactory.