Final Inspection Report

Sylvia Park Rest Home and Hospital

Date of Inspection: 5 July 2012

Contents

Executive summary

HealthCERT received a complaint from the Health and Disability Commissioner (HDC) on 2 July 2012 that raised serious concerns about the safety of vulnerable residents at Sylvia Park Rest Home and Hospital. The HDC requested that the allegations were investigated by HealthCERT.

The areas of concern identified in the complaint were as follows: falls management, clinical care, assessment, incident/accident reporting, infection control procedures, procedures for patients who require catheters, use of restraint, hours worked by staff, physical environment, and the state of equipment.

HealthCERT undertook an unannounced inspection of Sylvia Park Rest Home and Hospital on 5 July 2012 to determine whether the health care services being provided by Sylvia Park Rest Home Limited at Sylvia Park Rest Home and Hospital were in compliance with section 9 of the Health and Disability Services (Safety) Act 2001. A clinical nurse advisor contracted to Auckland District Health Board (DHB) assisted with the inspection.

The inspection identified areas where compliance with the Health and Disability Services Standards was not fully attained. These findings were in the areas of: consumer rights, quality and risk management, staffing levels and skill mix, evaluation of care, restraint, and equipment. All aspects of the complaint were substantiated. Auckland DHB was asked to immediately suspend the clinical nurse manager and initiate reassessment of residents whose healthcare had changed recently.

Sylvia Park Rest Home and Hospital is required to complete improvements to ensure compliance against the standards. Ongoing monitoring will be undertaken by the Ministry of Health in conjunction with Auckland DHB.

Previous recent complaints

No complaints have been received by HealthCERT since last certification audit.

Certification took effect on 10 August 2010. Certification expires on 10 August 2012.

The midpoint spot surveillance audit identified 8 partially attained (PA) criteria against the relevant Health and Disability Services Standards. Two of the PAs were rated as high risk, four moderate risk, and the remaining two rated low risk.

Service description

Sylvia Park Limited provides Aged Residential Care, Hospital and Rest Home services. The occupancy and capacity is outlined below:

Area	**Occupied**	**Capacity**
Hospital	56	57
Rest Home		
Dementia		
Maternity		
Total	**56**	**57**

Reasons for the inspection

The purpose of the inspection was to determine whether health care services being provided by Sylvia Park Rest Home Limited at Sylvia Park Rest Home and Hospital were 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.

Health and Disability service providers are required under section 9 of 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;and
(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, under the delegated authority of the Director-General of Health, and XXX XXX, Senior Contracted Clinical Nurse Advisor, Auckland DHB.

Methodology

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

The inspection was conducted using the following methods:

- Interview with Manager
- Interview with Registered Nurse (Clinical Leader)
- Individual staff interviews
- Relative/ Resident interviews
- Observation: During facility tours and casual 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 inspection process.
- Clinical notes review: A sample of residents' notes.

Limitations

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

Entry meeting

Present: XXX XXX (Ms), Owner, XXX XXX, Facility Manager, XXX XXX, Senior Advisor, HealthCERT, and XXX XXX, Contracted Clinical Nurse Advisor, Auckland DHB.

A copy of the letter of introduction addressed to XXX XXX was provided to her at 9.20am.

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.

Inspection findings

The following areas of non-compliance against the Health and Disability Services Standards were identified on the day of the inspection.

Consumer rights

Standard/Criteria	
1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.	**Finding: Partially Attained** Resident notes did not have clearly stated documentation for EPOA and there was no evidence of information available to residents for contacting an advocacy service, or resident meetings being held on a regular basis. There was no consideration given for the need of an advocate in respect of resident A, who had no family and was cognitively impaired. **CAR:** Ensure that residents have information regarding advocacy services and the ability to voice choice and have input into the service.
1.1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.	**Finding: Partially Attained** Abuse & Neglect Policy last reviewed 2009). There is no evidence of recent training on abuse and neglect - Elder Abuse training was scheduled August 2009, there is no record of sign off sheets confirming attendance/delivery. Manual handling training was provided 18 November 2010 however staff did not get to try or demonstrate the techniques used **CAR:** Ensure staff receives training in respect of Elder Abuse & Neglect.
1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based	**Finding: Partially Attained** The service has a significant number of policies in respect of systems and clinical management. There are a number of documents that have a review date recorded as 2009, some dating to 2007 which have not been reviewed. Manager interviewed stated that all policies are held on computer and updated by offsite consultant. There are no hard copies of policies or manuals available for staff. There is no sign off by manager/owner. **CAR:** Develop and implement systems to support opportunities for good practice including reviewing and updating clinical policies and providing training to support their implementation.

Standard/Criteria	
1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers	**Finding: Partially Attained** Accident/Incident last review Aug 2009. There was no Open Disclosure policy and no reference to the practice of open disclosure in associated documents. Incident reports reviewed did not indicate families were informed of incidents. **CAR:** Develop and implement a system to ensure notifications occur to relatives (e.g. notification of incidents & accidents).
1.1.9.4 Whenever necessary and reasonably practicable, interpreter services are provided	**Finding: Partially Attained** The service has mostly residents for whom English is a second language. On the day of inspection it was observed a sign was put up in English stating “Under Construction Do not enter to the new hospital wing”. There was no sign in Chinese. **CAR:** The service should access interpreter services and/or access assistance to implement communication aids when interpreters are not available.
1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	**Finding: Partially Attained** There was no clear documentation of how the advanced directives were signed and by whom within the residents’ files. It was evidenced that family members were signing on behalf of residents and there was no indication in resident’s files as to proof of Enduring Power of Attorney (EPOA). **CAR:** Ensure that the Advanced directive policy is reviewed and that staff are implementing the policy.
1.1.11.3 Service providers are educated to recognise this right to have an advocate/support person present and identify and appropriately address situation where an advocate/support person is not possible or appropriate.	**Finding: Partially Attained** Training records did not evidence training had been provided for staff in response to accessing advocacy services for residents. **CAR:** Ensure education in respect of Advocacy.
1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken	**Finding: Partially Attained** There is a complaints log but it is empty. The manager confirms that she does receive verbal complaints but prefers to deal with them herself directly. **CAR:** The service should have a documented process for all complaints to show that complaints have been followed up and action taken.

Organisational management

Standard/Criteria	
1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service deliver, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.	**Finding: Partially Attained** A range of operational and clinical policies were reviewed as part of an audit, not all aligned with best practice. The majority of policies are overdue for review - review dates ranging from 2006 with the majority due 2009 (including clinical policies). The risk management policy states a 2 year review interval will be used – this has not occurred. **CAR:** Review out dated policies and procedures to ensure they align with current good practice and service delivery. Implement service changes consistent with revised policies and procedures.

Standard/Criteria	
1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.	**Finding: Partially Attained** The Risk Management policy outlines timeframes for policy review as being 2 years unless indicated an earlier review is required. A number of the policies had a review date of 2009 (and earlier). **CAR:** Develop a document control system to effectively manage and control documents including the timely review and monitoring of documents.
1.2.3.6 Quality improvement data are collected, analyzed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	**Finding: Partially Attained** Monthly aggregation of incident/accidents is presented in bar graphs. There is no formulation of actions required when data is aggregated, no ongoing analysis or monitoring of trends. Staff meetings recommenced in January after a long gap (last August 2009) - minutes sighted confirm results are discussed with staff. **CAR:** Analyse quality data after collation identifying trends and risk minimisation/elimination strategies.
1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	**Finding: Partially Attained** Six of seven staff files reviewed did not contain references. **CAR:** Ensure references are included in staff files.
1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	**Finding: Partially Attained** Standards requirement is that in-service education is scheduled to occur monthly. There is an in-service training programme for the 2011/12 year. Content for 2012 was sighted but no evidence of training having occurred. No evaluations of any training that has occurred for 2010/2011 has taken place. A high proportion of staff has attended first aid training (for which each staff member paid $200). Little education has occurred for 2012. **CAR:** Ensure the scheduled ongoing education programme is implemented to ensure services provided by staff are safe and effective.
1.2.9.8 Service providers use up-to-date and relevant consumer records.	**Finding: Partially Attained** Resident records are updated by the Clinical Nurse Manager. Care givers do not write in the progress notes. Consumer care plans reviewed (x4 Hospital, x3 Rest home) and interventions are not documented and are not specific to guide care delivery. Assessments tools available were not always used to guide planning, for example, where a client had a high Waterlow score, interventions for reducing pressure area risk are not noted on the care plan. In the (7) care plans reviewed most had not been reviewed for over 12 months some had been reviewed one week prior to routine audit. **CAR:** Care Plans are updated to reflect care delivery.

Continuum of Service Delivery

Standard/Criteria	
1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.	**Finding: Partially Attained** Policy stated resident assessment is undertaken by an RN and an initial care plan is completed within three weeks of admission. RN designation was not noted on the initial assessment or on the long term care plan - the designation of the author is therefore unclear. Not all interventions were signed. Hospital client files (x4) viewed, x1 contained an initial assessment as a recent admission. For example, pain management was identified as a need, but there was no pain management planning place to direct initial care. There is a policy that states the Physiotherapist assesses all residents for falls. In consumer files viewed (x7), all falls assessments were completed by the Registered Nurse, and not according to the policy. **CAR:** a) Signature and designation is noted on the client records relating to all aspects of service provision, and meet standards, as per 1.2.9.9. b) Align practice and policy in relation to completing falls assessments.
1.3.3.2 1 Each stage of service provision (assessment, planning, provision, evaluation, review and exit) is developed with the consumer, and where appropriate their family/whanau of choice or other representatives as appropriate.	**Finding: Partially Attained** Three of eight care plans did not document on the care plan who had been involved in the care planning process. Six-week post admission surveys were not completed in eight of eight files reviewed. **CAR:** Care plans to document who has been involved in the care planning/review process. Six week post admission surveys to be completed as per policy.
1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review and exit) is provided within time frames that safely meet the needs of the consumer.	**Finding: Partially Attained** There are a number of assessment tools available to guide service provision requirements. In the review of consumer files (x7), none had been reviewed within appropriate timeframes (6 months), and x7 files were inconsistent in assessment, planning, review and evaluation. Staff confirmed they were aware of clients' needs, but this was not evidenced in the short term or long term documented planning. Short term care plans, when in place, were scant in detail. For example, with infections or wound care. **CAR:** Care plans have assessments, planning, interventions and reviews within measurable time frames to ensure safe care is provided.
1.3.6.1 The provision of services and/or interventions is consistent with, and contributes to, meeting the consumers/ assessed needs, and desired outcomes.	**Finding: Partially Attained** The interventions for service delivery do not provide enough detail for individualised and consistent service delivery. Of the files reviewed, assessments were incomplete, care plans that identified some areas of need did not have corresponding interventions consistent with the assessments undertaken. For example, a consumer with a high Waterlow score did not have specific interventions for reducing pressure area risk noted on the care plan. **CAR:** Care plans record intended outcomes and interventions to provide consistent services.

Standard/Criteria	
1.3.8.1 Evaluations are conducted at a frequency that enables regular monitoring of progress towards achievement of desired outcomes.	**Finding: Partially Attained** Policy: Delivery of Nursing Care: review date Feb 2011 states residents' comprehensive support and care plan is evaluated, reviewed and amended when clinically indicated or six monthly. All of the seven care plans reviewed were not completed within six months. **CAR:** Evaluations are completed within 6 months to reflect individual consumer needs.
1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols and guidelines.	**Finding: Partially Attained** There is a medication fridge in the make shift office. No evidence of fridge temperature monitoring was evidenced occurring. **CAR:** Medication fridge temperature to be monitored.
1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	**Finding: Partially Attained** Medication policy states that all staff administering medications are required to have an annual competency check. The Clinical Nurse confirms there is a verbal competency check but has not been completed "for some time". The clinical Nurse Manager states that she completes the competency check for all other registered staff. When asked what competencies she was auditing against (i.e. competencies for registered nurses) she confirmed none. **CAR:** Undertake regular formal competency checks for all staff administering medication consistent with the facility policy, and priorities staff medication training needs in relation to consumer risk.

Safe and Appropriate Environment

Standard/Criteria	
1.4.1.4 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.	**Finding: Partially Attained** There was no evidence of training in hazardous substance/waste management. Staff interviewed were aware of the appropriate way to manage waste - laundry supervisor confirmed nursing staff use the different linen bags appropriately. **CAR:** Implement training on hazardous waste management.

Restraint Minimisation

Standard/Criteria	
2.2.2.1 In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: a) Any risks related to the use of restraint; b) Any underlying causes for the relevant behaviour or condition if known; c) Existing advance directives the consumer may have made; d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; e) Any history of trauma or abuse, which may have involved the consumer being held against their will; f) Maintaining culturally safe practice; g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); h) Possible alternative intervention/ strategies.	**Finding: Partially Attained** There is no evidence of the annual review process and quality improvement schedule which includes restraint minimisation and safe practice. The facility manager/restraint coordinator is newly appointed to her position and quality review of the restraint monitoring has yet to occur. There is also no documented evidence that restraint approval group meetings occur. **CAR:** Ensure that quality review of restraint practices occur and restraint approval group meetings take place.

Infection Prevention and Control

Standard/ Criteria	
3.1.3 Policies and procedures (whether or not developed by contracted services or in house services) that may affect the transmission of infection shall clearly identify who is responsible for the policy development and implementation, and shall be consistent with infection control policies and principles. Processes shall be in place to ensure ongoing infection control team/personnel involvement.	**Finding: Partially Attained** The infection control programme is not implemented as defined within the infection control policy. The programme has not been reviewed annually. **CAR:** Ensure the infection control programme is reviewed resulting in a clearly defined and documented programme.

Summation meeting

A summation meeting was attended by: XXX XXX (Ms), Owner, XXX XXX, Facility Manager, XXX XXX, Clinical Nurse Manager, XXX XXX, Senior Advisor, HealthCERT, and XXX XXX, Auckland DHB.

The HealthCERT Advisor thanked facility staff 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 Advisor confirmed that there would be findings against the Health and Disability Services Standards as per the above table.

Sylvia Park Rest home Limited is required to take the above corrective actions to improve compliance against the Health and Disability Services Standards. Ongoing monitoring will be undertaken by the Ministry of Health in conjunction with Auckland DHB.

Conclusion

The unannounced inspection was focussed on the Health and Disability Services Standards relevant to the allegations in the complaint. All aspects of the complaint were substantiated.

In summary, the findings were:

Resident Rights:

- no evidence of abuse was found, however there is evidence of neglect and this is related to the lack of a comprehensive and accurate nursing assessment of residents.

- resident choices and decisions are not always clearly documented within care plans
- policy on advance directives needs reviewing and staff education carried out to ensure the policy is implemented
- Residents do not have information regarding advocacy services and the ability to voice choice and have input into the service.

Organisational management:

- management does not have training in health care provision for the elderly
- there is little clinical oversight and staff management in place to ensure resident safety
- in the temporary absence of the clinical manager a suitably qualified and/or experienced person is not available to perform this role.
- adverse, unplanned, or untoward events including service shortfalls are not documented and opportunities to improve service delivery, and to identify and manage risk do not occur
- the Open Disclosure policy was not always followed and family/whanau are not always kept informed regarding all events
- there was not a process/policy implemented for staff level and skill mix to ensure safe care for residents, including registered nurse clinical hours
- documentation was not always entered and integrated into the residents' files and accessible for staff and allied health providers. There was poor documentation in residents' notes when an accident or injury had occurred.

Continuum of Service Delivery:

- all residents did not have full clinical assessment, care plans were written without clear guidelines for staff to follow regarding safe care of residents. The care plans were not evaluated and changed/updated to ensure safe care for residents
- care plans were not informative and did not set clear goals including resident choice, and residents and/or family/whanau were not included in their development.
- a team approach with other allied health was not included within a coordinated team
- the service did not respond by initiating changes where progress was different from expected
- assistance was not sort when required and residents were not referred to other services or for assessment and residents and family/whanau were not informed.

Safe and Appropriate Environment:

- staff were not provided with equipment to safely meet the needs of residents.

Restraint Minimisation:

- residents were not assessed as to whether restraint would be used by a suitably qualified service provider
- restraint observations and monitoring were not adequate and in maintaining the safety of the consumer.

Infection Prevention and Control:

- the infection control programme is not implemented as defined within the policy.

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: 1.1.3.7, 1.1.8.1, 1.1.9.1, 1.1.10.7, 1.1.13.3, 1.2.3.4, 1.2.3.6, 1.2.9.8, 1.3.3.1, 1.3.3.2, 1.3.3.3, 1.3.6.1, 1.3.8.1, 1.3.12.1, 1.3.12.3, 1.4.1.4, 3.1.3 as identified in the Inspection Report must be submitted to Auckland District Health Board by 10 September 2012.

2. A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards: 1.1.9.4, 1.1.11.1, 1.1.11.3, 1.2.3.3, 1.2.7.3, 1.2.7.5, 2.2.2.1 as identified in the Inspection Report must be submitted to Auckland District Health Board by 10 November 2012.

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.

Appendix 1: 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