Final Inspection Report

Bupa Care Services NZ Limited - Elizabeth R Rest Home and Hospital

Date of inspection: 5 December 2013

HealthCERT
Provider Regulation
Clinical Leadership, Protection and Regulation

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1. Provider Details

Provider:	Bupa Care Services NZ Limited – Elizabeth R Rest Home and Hospital
Premises:	Elizabeth R Rest Home and Hospital
Contact Person:	Shay Gurney
Internal File Ref:	**G00178 - C50**
Inspection Date:	5 December 2013

2. Executive summary

The Ministry of Health (the Ministry) received a copy of a complaint dated 18 November 2013 to [redacted], Taranaki District Health Board (DHB), regarding the care provided to a resident (Mr A) at Elizabeth R Rest Home and Hospital. The complainant was the residents' daughter.

The complaint raised concern that Bupa Care Services NZ Limited – Elizabeth R Rest Home and Hospital could have been in breach of its obligations as a provider certified under the Health and Disability Services (Safety) Act 2001 (the Act) to provide health care services at Elizabeth R Rest Home and Hospital.

In summary, the complainant alleged that:

- her father had been referred to the DHB's mental health service for older people for assessment only three days after admission and on at least two other occasions during the first two weeks
- she received regular phone calls from staff asking family to go to the hospital to assist with feeding her father as they were understaffed
- her father had an [redacted] and there was no explanation as to how this had occurred
- her father was prescribed antibiotics for the [redacted], but did not receive them until 48 hours later
- there was a shortage of staff
- her father was restrained inappropriately for long periods.

As a result of this complaint, an unannounced inspection of Elizabeth R rest home and hospital was undertaken by the Ministry on 5 December 2013 in accordance with sections 40, 41 and 43 of the Act.

On the basis of evidence reviewed, the Ministry concluded that Bupa Care Limited had failed to fully comply with relevant Health and Disability Services Standards (NZS 8134:2008). The partially attained standards related to complaints management, planning, restraint minimisation, good practice, and family/whanau involvement in care planning. Some aspects of the complaint were substantiated, and Bupa Care Limited is required to undertake the corrective actions outlined in section six. Ongoing monitoring will be undertaken by the Ministry in conjunction with Taranaki DHB.

3. 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, and the standard approved is the Health and Disability Services Standards NZS 8134:2008.

Facts

a) The complainant was concerned that her father had been referred to the DHB's mental health service for older people for assessment three times within the first two weeks of admission.

There was evidence of two formal assessments, one occurring just prior to admission and a second assessment on the third day of admission. The manager confirmed that he had also made a third verbal request to have the resident reassessed for a secure dementia unit.

The inspection validated that the referrals did occur, however, that is not considered a breach of the health and disability services standards, as providers are required to refer residents when changes to care levels are identified. These referrals were documented in the resident file.

b) The complainant alleged that her father had developed an infected wound on his [redacted] with a number of other skin tears present. She believed the injuries had occurred as a result of her father being restrained.

Mr A's file contained an incident form dated 8 November 2013 that described two skin tears to [redacted], one on the [redacted] and another on the lower part of [redacted]. The cause was written as *"? secondary to the lap belt rubbing …. or ? secondary to the chair"*.

Mr A's daughter alleged that, while visiting on 12 November 2013 to attend the general practitioners (GP's) round, she noticed her father's [redacted] was very red, swollen and appeared infected. This was brought to the attention of both the GP and the registered nurse on duty. The GP prescribed antibiotics.

Mr A's daughter alleged that she spoke to the manager about her fathers [redacted]. She alleged that the manager confirmed Mr A had commenced the antibiotics that same day.

On 14 November 2013, Mr A's daughter attended a meeting with the manager and the community nurse who would be undertaking an assessment review at the request of the manager. The daughter alleged that, prior to the meeting, the registered nurse explained to the family that there had been a delay in starting the antibiotics because the GP had not filled in the prescription correctly. Mr A's daughter was advised on the same day by the registered nurse that the prescription had been mislaid.

Mr A's medication chart showed that the prescribed antibiotics were first administered on 14 November 2013, two days following the GP's visit.

c) ***The complainant alleged that she noticed there were only ever two staff on duty and the staff had complained they were short staffed and could not look after her father***

The manager produced a file note in relation to the meeting held with two of Mr A's daughters. The file note signed by the manager stated that he advised the family that if Mr A could not settle into the new home and if he continued to be uncooperative/aggressive then the manager would be unable to keep him safe, therefore a more appropriate environment should be sought (dementia unit).

- The file note also outlined a conversation held with [redacted] that the manager could not guarantee Mr A's safety and was unable to manage his behaviour due to the layout of the building and staffing levels.
- Bupa has a verifiable process to determine staffing levels relevant to occupancy levels. The 'Wage Analysis Scale [WAS] is a tool that has been based on the guidelines "Indicators for Safe Aged-Care and Dementia care for consumers – 8163:2005.

A review of the complaints register identified there was a complaint dated 11 October 2013 from a family about the shortage of staff.

On the day of the inspection a sample of rosters was sighted during the period of Mr A's admission. There was evidence of inadequate staffing coverage in relation to the acuity of the residents at that time.

d) ***The complainant alleged that her father was restrained because of the staffing shortage and the restraint was inappropriate, causing injury to her father's [redacted].***

The restraint record in Mr A's file did not have sufficient detail to demonstrate there was adequate and appropriate observation, care, dignity, respect. Restraint records were commenced from the date of his admission 23 October, but did not provide a full account of each episode of restraint use and there were gaps in restraint monitoring documentation.

There was no evidence of ongoing assessment occurring to minimise the risk of harm to Mr A during restraint. Alternatives to restraint use were not well documented.

The Ministry concluded that there was evidence of three referrals within the first three weeks of Mr A's admission. This is validated and not considered a breach of the standards.

Based on the evidence reviewed on the day of the inspection, the Ministry concluded that the following aspects of the complaint were substantiated.

I. There was evidence from medical and nursing notes of skin tears and an infected skin tear to Mr A's [redacted].

II. The restraint assessment process had not been followed appropriately. There was no evidence of a restraint assessment prior to Mr A being restrained.

   a. The form used for monitoring a resident while being restrained was inconsistently completed.
   b. The frequency and level of observation and assessment appropriate to the level of potential risk and harm to Mr A could not be evidenced.

III. As stated by staff on the incident form dated 29 October 2013 the intent of the restraint intervention was as a result of a staff shortage. There was no evidence in the file of any clinical rationale.

Certification

Bupa Care Services NZ Limited – Elizabeth R Rest Home and Hospital is certified for one year following a provisional audit as a result of the purchase of the business. The current certificate expires 1 July 2014.

4. Inspection team

The inspection was undertaken by [redacted] and [redacted], Senior Advisors HealthCERT, Ministry of Health, under delegated authority of the Director-General of Health.

5. Inspection process

The following process was used during the inspection:

- Interview with Facility manager/clinical manager
- Interview with registered nurse
- Interview with care giver
- Physical inspection of premises/equipment
- Review of clinical records.

6. Inspection limitations

The scope of the inspection was limited to the issues raised in the complaint made by the complainant and criteria within the Health and Disability Services Standards relevant to the complaint.

7. Inspection findings

Findings have been reported against the following standards:

- Health and Disability Services Standards 8134.1:2008 Core Standards
- Health and Disability Services Standards 8134.2:2008 Restraint Minimisation and Safe Practice

Relevant Standard/Criterion	Findings	Required Corrective Action/s	Rating and time frame.
Standard 1.1.13	Not all complaints were logged into the complaints register. There was no documentation in the complaints register that demonstrated that complaints had been responded to within the specified timeframe according to policy.	**Corrective Action Request:** Ensure the complaints register is sufficiently detailed and includes all actions undertaken with evidence of correspondence to complainant acknowledging complaint and any further correspondence.	**Rated:** Moderate **Time frame:** Three months

Relevant Standard/Criterion	Findings	Required Corrective Action/s	Rating and time frame.
Standard 1.2.8	The organisation (Bupa Care Services Limited) has a policy and process for determining staff levels. This inspection noted that staffing rosters did not adhere to this process and in the sample of rosters sighted, there was evidence of reduced staffing levels.	**Corrective Action Request** Ensure Bupa policy for determining staffing levels is implemented at this facility.	**Rated:** Moderate **Time frame:** Two months
Standard 1.3.5	The six files reviewed in the hospital unit did not clearly identify strategies for minimising episodes of challenging behaviours based on assessment and prevention. In four of the six files reviewed there was no evidence of family/whanau input.	**Corrective Action Request:** (i) Ensure the care plan describes the required supports and interventions to achieve the desired outcomes identified by the ongoing assessment process. (ii) Ensure family/whanau are involved in service provision planning.	**Rated:** Moderate **Time frame** Three months
Standard 2.1.	1) The facility has a policy on restraint minimisation but was not able to demonstrate this in practice for this resident. 2) On the day of inspection, the staff interviewed were not able to identify who the restraint coordinator was.	**Corrective Action Request** Ensure there is a clearly defined process for determining restraint in the restraint policy, and the restraint coordinator is clearly identified. Ensure that the policy on restraint minimsaiton is implemented at this facilityand restraint assessments are completed prior to restraint use.	**Rated:** Moderate **Time frame** Three months
Standard 2.2.	Each episode of restraint was not documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, outcome, as considered in the criteria list a-h.	Ensure that monitoring and documentation occurs during each episode of restraint.	**Rated:** Moderate **Time frame** Three months
Standard 2.3.	There was no evidence of the continued use of restraint being continuously monitored and regularly reviewed to ensure it is applied for the minimum amount of time as necessary.	**Corrective Action Request:** (i) Ensure that monitoring and continuous review of restraints are occuring (ii) Ensure that evaluations are occuring as required and are documented.	**Rated:** Low **Time frame** Three months
Standard 2.5	There was no comprehensive review of restraint practices in order to determine (a) to (h) are met.	**Corrective Action Request:** Ensure there is a review of the restraint practices and this is well documented.	**Rated:** Moderate **Time frame** Three months

8. Meeting at end of inspection

Present: ██████ and ██████, Senior Advisors, HealthCERT; Craig Scaman facility manager, by teleconference; ██████, Taranaki DHB Portfolio Manager; Gail Smith, Bupa Care Services (NZ) Limited.

[redacted] thanked the management team and 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 provider was advised that this investigation report would be published on the Ministry website.

Key points discussed at the summation were:

- issues raised by the complainant appeared to be substantiated but further analysis was required to confirm this
- not all complaints were registered in the complaints register and management of complaint documentation required improvement
- restraint minimisation and safe practice had not been adhered to
- there were inadequate staffing levels when residents' needs were high
- failure to ensure that Mr A received the prescribed medication at the right time.

9. 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. Bupa Care Services (NZ) Limited – Elizabeth R Rest Home and Hospital is required to undertake the corrective actions outlined in section six 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.