



# **Final Inspection Report**

## **Home of St Barnabas**

**Date of inspection: 21 January 2014**

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## Provider Details

Provider:	Home of St Barnabas Trust
Premises:	Home of St Barnabas
Contact Person:	██████ (Manager)
Internal File Ref:	G06582-C01
Inspection Date:	21 January 2014

### 1. Executive summary

The Ministry of Health received a complaint via the Southern District Health Board (DHB) which alleged the Home of St Barnabas Trust could have been in breach of its obligations as a certified provider under the Health and Disability Services (Safety) Act 2001 to provide services at Home of St Barnabas.

The complaint was from ████████ and alleged that there was a poor standard of care provided to her mother, ████████.

In addition, the DHB advised the Ministry that its ██████ visited the Home of St Barnabas on 10 January 2014. The ██████ noted a number of issues of concern in addition to corroborating issues of concern raised in the complaint. The ██████ found:

- residents with dementia who were wandering, were not being monitored properly, and had not been referred for reassessment
- medication errors
- residents who were ill that had not been checked by a registered nurse
- a patient who had sustained a fall and was not checked until five hours later
- lack of communication between the registered nurses working at the facility.

As a result of the complaint, and the issues raised by the visiting ██████, an unannounced inspection of the Home of St Barnabas was undertaken by the Ministry on 21 January 2014 in accordance with sections 40, 41 and 43 of the Act.

The Ministry concluded that three of five aspects of the complaint and concerns raised by the DHB were substantiated. The Home of St Barnabas Trust had failed to fully comply with relevant Health and Disability Services Standards (NZS 8134:2008). The partially attained standards related to adverse event reporting, assessment, planning, and service and delivery/interventions. The Home of St Barnabas Trust is required to undertake the corrective actions outlined in section six.

Ongoing monitoring will be undertaken by the Ministry in conjunction with Southern DHB.

### 2. 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) *Residents with dementia who were wandering***

There was evidence that one resident (Resident A) had absconded on 3/1/14 for four hours. Local police were notified and the resident was returned by police. File notes evidenced that Resident A was found wandering on the streets again on 10/1/14. There was no evidence of changes to Resident A's care plan in respect of need for close monitoring following the first incident. No notification had been made to the Ministry of Health as required under Section 31 of the Act.

There was evidence that Resident A's family had been notified on 3/1/14 of the wandering incident. On 13/1/14 the resident was assessed by a DHB [REDACTED] and was awaiting referral for a formal assessment by the DHB's Needs Assessment and Service Co-ordination unit.

Resident A's care plan noted in October 2013 that there were issues with wandering. The resident was not reassessed by the Needs Assessment and Service Co-ordination unit until the day of the inspection (21 January 2014) for a higher level of care. No short term care plans or long term care plan changes were evidenced since wandering had become an issue. It was only noted in the progress notes that 30 minute observations were required.

Six of 41 files reviewed had no evidence of behavioural assessments. It was noted in the quarterly quality report that 15 percent of issues reported were around challenging behaviour.

#### **Substantiated**

#### **b) *Medication errors***

It was observed that both staff conducting medication rounds had left their trolleys unattended in two different areas. The organisation's medication policy was out of date and last reviewed on 1 October 2011. There were six medication charts sampled that did not meet the required standard for the safe administration of medicines.

#### **Substantiated**

#### **c) *Residents who were ill that had not been checked by a registered nurse***

This aspect of the complaint could not be substantiated.

#### **Not substantiated**

#### **d) *A resident who had sustained a fall and was not checked until five hours later***

On the day of the inspection, a resident that was interviewed stated she reported that she had fallen and had got herself up off the floor. When this resident's file was reviewed, an incident form about the fall had been initiated. There was evidence that the resident was checked for injuries but no evidence of an assessment by a registered nurse after the fall. The date on the incident form was dated 10 January 2014. There was no mention of the incident in the resident's

progress notes and the incident was not signed off by a registered nurse until 17 January 2014.

### **Substantiated**

#### **e) *Lack of communication between the registered nurses working at the facility***

The inspection team arrived at 0750 and spoke with the registered nurses who contacted the General Manager who arrived at 0830. There did not appear to be a clinical manager in the organisational structure however there is a Care Manager. The Kitchen Supervisor deputises for the manager during her absence.

### **Not substantiated**

#### *Certification*

The provider is currently certified for three years with an expiry date of 17 August 2015. The previous certification audit identified four low-risk partial attainments against the required standards.

### **3. 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.

### **4. Inspection process**

The following process was used during the inspection:

- Interview with the Manager
- Interview with registered nurse
- Physical inspection of premises/equipment
- Review of clinical records – resident files, medication charts, accident hazard event forms

### **5. Inspection limitations**

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

### **6. Inspection findings**

Findings have been reported against the following standards:

- Health and Disability Services Standards 8134.1:2008

Relevant Standard/Criterion	Findings	Required Corrective Action/s	Rating and time frame.
<b>Standard 1.2.4</b>	<p>The incident and accident forms reviewed were incomplete. There was evidence of inconsistencies when informing family. Unacceptable length of time taken before the registered nurse had reviewed the forms.</p> <p>Evidence of one resident having fallen on three occasions during the last six weeks and there were no changes made to their care plan in respect of this.</p>	<p><b>Corrective Action Request</b></p> <p>Ensure all accident and incident forms have been filled in completely, and corrective actions plans have been developed.</p> <p>Ensure RN undertakes an assessment of the resident as close to the event as possible, and care plan changes are made.</p>	<p><b>Rated:</b> Moderate</p> <p><b>Time Frame:</b> Two months</p>
<b>Standard 1.3.3</b>	<p>On the day of the inspection the registered nurse confirmed there were five residents with dementia. One resident recently absconded and was returned by the police four hours later. This event was not reported under Section 31 of the Act to the Ministry.</p> <p>Resident A's and three other files were reviewed. In October 2013 it is noted in the progress notes that there were issues with Resident A wandering. A referral for a higher level of care was not made at the time. A NASC assessment was completed on the day of inspection.</p> <p>Five files out of six did not have family/whanau involvement in care planning or evaluation. There was evidence of lengthy delays with evaluations.</p>	<p><b>Corrective Action Request:</b></p> <p>Ensure referrals are made in a timely manner to meet the residents changing needs.</p> <p>Ensure family/whanau is given the opportunity to participate in care planning and in the evaluations on a regular basis.</p>	<p><b>Rated Moderate</b></p> <p><b>Time Frame</b> Three months</p>
<b>Standard 1.3.4</b>	<p>Needs Assessment and Service Co-ordination Service assessments were not always evident in six files reviewed. Not all assessments were completed and up to date. There were regular mental health assessments undertaken, however there was no outcome or action from them documented and no further follow up.</p> <p>In six files reviewed there was lack of consistency with assessments being updated such as pain, continence, behaviour or nutrition. In four of the six files no pain assessments had been evidenced despite the history of all three residents complaining of pain for various ailments.</p>	<p><b>Corrective Action Request:</b></p> <p>Ensure all assessments are consistently completed and updated as required and the needs and outcomes identified via the assessment process are documented to serve as a basis for service delivery planning.</p>	<p><b>Rated Low</b></p> <p><b>Time Frame</b> Three months</p>
<b>Standard 1.3.7</b>	<p>In all six resident files reviewed there was poor documentation for activities assessments and plans. Plans were incomplete and not individualised for each resident.</p>	<p><b>Corrective Action Request:</b></p> <p>Ensure activity are planned and developed consistently. Where possible the preference of consumers' needs to be sought and documented.</p>	<p><b>Rated Moderate</b></p> <p><b>Time Frame</b> Three months</p>

Relevant Standard/Criterion	Findings	Required Corrective Action/s	Rating and time frame.
<b>Standard 1.3.8</b>	Evaluations of care plans, activities and wound management were inconsistent. There were lengthy gaps between evaluations and in some instances no evaluations for activities had occurred for over twelve months.	<b>Corrective Action Request:</b> Ensure evaluations occur at a frequency that allows monitoring of progress towards desired outcomes. When evaluations demonstrated a change in resident's care needs then evidence of updated care plans is required.	<b>Rated Low</b> <b>Time Frame</b> Three months
<b>Standard 1.3.12</b>	Of thirteen charts reviewed six charts had no photograph ID of resident. Seven of thirteen charts did not have three monthly GP reviews. Two of thirteen charts had no medication reviews undertaken since 2010. Evidence of transcribing warfarin in two of thirteen charts. Ten of thirteen charts had a faxed medication chart that staff administered from. Evidence of short term medications not being discontinued in six charts. No evidence of a weekly stock count in red in the controlled drugs registers.	<b>Corrective Action Request:</b> Ensure transcribing ceases immediately. GP three monthly reviews must be consistently maintained as per the Medications Guidelines. The practice of using the faxed medication charts in place of updated original charts must cease immediately. The GP must update the medication chart within 48 hours. Ensure medications that are short term are discontinued by GP. Ensure there is a weekly stock count in red in the controlled drugs register. Ensure there is a six monthly physical stocktake and reconcillation.	<b>Rated High</b> Two months

## 7. Meeting at end of inspection

Present: [REDACTED] and [REDACTED], Senior Advisors, HealthCERT, Ministry of Health; [REDACTED], General Manager Home of St Barnabas; [REDACTED], registered nurse; [REDACTED], Kitchen Supervisor; [REDACTED], House Supervisor; [REDACTED] and [REDACTED], Southern DHB Portfolio Managers.

[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 of Health website.

Key Issues raised at the summation were:

- Some of the issues raised by the complainant and DHB appeared to be substantiated but further analysis was required to confirm this
- Failure to complete a Section 31 notification to the Ministry when residents have absconded from the facility.
- No evidence that a registered nurse is undertaking a physical assessment of residents who have had a fall.
- Lack of timely NASC re-assessment and corrective actions following the above event and when there is a deterioration in resident's conditions

- Ensure medicine management processes meet the required standard
- Lack of documentation in resident files of short term care plans when increasing monitoring is required, lack of care plan changes when a resident having multiple falls, and changes not being made to long term care plans when there are changes to the residents care needs.

## **8. 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. St Barnabas Home Trust 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.

Home of St Barnabas Trust was given a copy of the draft report and asked to comment on any factual errors. █████ responded in a letter dated 12 March 2014. The Ministry accepted that there were some errors in the draft report and a revised draft report was sent to █████ on 27 March 2014. No further feedback was received from █████ and the revised draft report has been finalised.