Final Inspection Report

Aranui Home and Hospital Limited

31 January 2013

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

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1. Provider Details

Provider:	Aranui Home and Hospital Limited
Premise:	19 Woodward Road Mt Albert Auckland
Contact Person:	Mr Michael Crouch
Internal File Ref:	WAR12
Inspection Date:	31 January 2013

2. Executive Summary

The Ministry of Health (Ministry) and Auckland District Health Board (DHB) received a complaint from the Health and Disability Commissioner (HDC) that alleged Aranui Home and Hospital Limited could have been in breach of its obligations as a certified provider under the Health and Disability Services (Safety) Act 2001 (the Act) to provide services at Aranui Home and Hospital.

The complaint alleged that:

- staff were not treated with respect and were sworn at in public
- staff were rostered to fill shifts when they were not appropriately skilled or qualified to perform the duties
- staff were "forced" to work extra shifts
- rosters were changed at short notice and without consultation
- staff did not receive suitable orientation
- residents were not receiving a reasonable level of care
- complaints by staff were ignored

As a result of this complaint, an unannounced inspection was undertaken by the Ministry on 31 January 2013 pursuant to sections 40 to 47 of the Act.

The DHB advised HealthCERT that it had met with the manager of Aranui Home and Hospital and had requested a written response to this HDC complaint within two weeks (due 1 February 2013). This request has not been met.

Summary of findings in respect of the complaint:

1. Staff were not treated with respect and were sworn at in public

Staff interviewed acknowledged this had occurred although in a staff only area. Staff were also unhappy that the issue was not dealt with by management.

Outcome - Partially Substantiated

2. Staff were rostered to fill shifts when they were not appropriately skilled or qualified to perform the duties

Interviews with staff revealed that the manager had recently made two significant changes to the rosters and places of work. These changes had been signalled only

in an ad hoc manner to some staff prior to them coming into effect. The planned changes were for all clinical staff (registered nurse and care givers) to be rostered on duties as per their contract and not on the shifts that they had individually negotiated over a number of years.

All staff now rotate to the three distinct clinical areas (rest home, dementia unit and hospital) rather than allocated to one area. The result of these changes has left staff feeling insecure in their new work areas and lacking requisite skills i.e no dementia training for staff in dementia areas.

Outcome – Substantiated

3. Staff were "forced" to work extra shifts

With the new rotation of shifts and clinical areas, some staff stated their hours had been reduced without consultation and that they felt they had to accept extra shifts to make up the short fall in wages. This issue did not apply to all staff.

Outcome - out of scope

4. Rosters were changed at short notice and without consultation

The facility policy states that new rosters must be prepared and available to staff two weeks in advance. This had not occurred recently and had led to staff being unable to plan. Review of the roster noted multiple changes and no evidence of staff consultation for any changes. Staff reported that the roster was frequently changed at the last moment without any consultation.

Outcome – Substantiated

5. Staff did not receive suitable orientation

The new rotation process had resulted in occasions when a new team was on a shift and none of the staff had knowledge of the residents' needs within that service area. There was no familiarisation process to assist staff when rotated to a new area. Staff who had previously worked in the rest home area and had now been assigned to the hospital area had no formal training on hoist use prior to relocating to the new work area. The orientation for new staff to the facility was still not developed and this was highlighted at the recent recertification audit.

Outcome- Substantiated

6. Residents were not receiving a reasonable level of care

As a direct result of the staff rotation, the residents were receiving inadequate care. At interview, staff stated they were unfamiliar with their new patient groups, especially in the dementia unit as there had been no familiarisation or orientation to the unit or to the residents, and no formal education had been received. Also staff who had previously worked in the dementia unit and had been moved to the hospital area lacked training in hospital equipment e.g. hoists. During the review of randomly selected clinical files, the care plans were not aligned with current resident needs. There was no evidence of assessment tools for pain, behaviour, wound care, skin integrity, or restraint. This issue was also raised at the recent recertification audit and little progress had been made.

Outcome - Substantiated

7. Complaints by staff were ignored

It was evident from documentation and interviews that verbal complaints were not being recorded and actioned. The complaints register (which did not exist prior to the November 2012 certification audit) could not be located. For the written complaints that were examined, there was no evidence of review or actions. There were a number of complaints on written complaint forms in the manager's office dated from November 2012 that still required responses.

Outcome – Substantiated

Conclusion

Of the seven allegations made in the HDC complaint, one was considered out of the Ministry's scope and the remaining six allegations were substantiated either partially or in full.

Other incidental findings during the inspection were:

- The number of staff hours rostered to the Dementia wing did not meet the Standards NZ 8163:2005 Indicators for Safe Aged Care and Dementia Care for Consumers. In this unit staff were required to undertake additional duties of laundry, activities in the afternoon, and kitchen duties that took them away from direct care. Calculation of rostered hours showed a deficit of 75 hours
- A random review of clinical files showed care plans not completed, individual care plans needed to be developed, only exception reporting with no record of daily progress to care plans and changes, and some residents notes were updated on night shift with minimal information provided.
- Notebooks were used in each clinical area containing resident information and actions taken – these notes differed from the record in the resident file.
- The medications management policy (July 2012) requires all health care assistants who administer medications to complete and pass an annual medication competency test. Staff have been identified as not completing medication competency prior to moving to either the rest home area or dementia area.

Both the inspection findings in relation to the complaint and other incidental findings during the inspection were consistent with the certification audit findings in November 2012. The certification audit found a significant number of only partially attained criteria under the Health and Disability Services Standards (2008) and resulted in a one year period of certification. There was little or no evidence that any significant progress had been made since that audit.

Corrective Actions Required

Aranui Home and Hospital is required to implement the following corrective actions

- Ensure a system is maintained to record and resolve complaints in accordance with relevant legislative requirements. Complaint register to record verbal and written complaints. (HDSS 1.13) 1.1.13.1 time frame one month.
- Provide evidence that All staff have completed or are enrolled in the national standards in dementia care (required in the Age-Related Residential Care service agreement (E4.5)), and that all caregivers directly involved in caring for residents in the Dementia Unit have passed the required training and education. (HDSS 1.2.7) 1.2.7.5 time frame

three months.

- Provide evidence that processes to identify how staffing needs are reviewed and changed to ensure the resident's needs are being met. (HDSS 1.2.8) 1.2.8.1 time frame one month.
- Ensure medication competencies are current for all staff who transfer between service areas (HDSS 1.3.12) 1.3.12.1 time frame one month.
- Ensure all staff have received training to respond to identified emergency and security situations, including fire evacuation procedures for their specific clinical placement area. (HDSS 1.4.7) 1.4.7.1 time frame two months.
- Ensure education training is completed on prevention and de-escalation techniques in the challenging behaviour education and the education is on-going, (HDSS 2.1.1.5) timeframe two months.

Additional conditions to be placed on the Certification Schedule

Pursuant to section 28 of the Health and Disability Services (Safety) Act, the Director-General of Health may attach any condition the Director-General thinks necessary or desirable to help achieve the purpose of this Act.

Additional Conditions

The following conditions are to be included on the certification schedule of Aranui Home and Hospital:

- A written progress report that outlines all actions undertaken by the Provider in relation to corrective actions 1.3.12.3, 1.1.13.1, 1.2.8.1 as identified in the Inspection Report must be submitted to your District Health Board within one month of the issue of the amended schedule. Your District Health Board will notify the Director-General of Health of progress, if any, if required in accordance with the Ministry of Health's requirements for the processing of progress reports.
- A written progress report that outlines all actions undertaken by the Provider in relation to corrective actions 1.4.7.1, 2.1.1.5 as identified in the Inspection Report must be submitted to your District Health Board within two months of the issue of the amended schedule. Your District Health Board will notify the Director-General of Health of progress, if any, if required in accordance with the Ministry of Health's requirements for the processing of progress reports.
- A written progress report that outlines all actions undertaken by the Provider in relation to corrective actions 1.2.7.5 as identified in the Inspection Report must be submitted to t your District Health Board within three month of the issue of the amended schedule. Your District Health Board will notify the Director-General of Health of progress, if any, if required in accordance with the Ministry of Health's requirements for the processing of progress reports.
- 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.

3. Background

Aranui Home and Hospital Limited underwent a certification audit on 22 November 2012 that resulted in a one year certification period. Aranui is an 85-bed facility providing hospital (medical and geriatric), rest home, including and excluding dementia level care. There were 82 residents on the day of the audit. A new General Manager was employed in March 2012

and a new clinical co-ordinator in September 2012. The audit identified 46 partially attained criteria against the relevant Health and Disability Services Standards.

Previous Complaints known by the Ministry of Health:

There were two previous HDC complaints. Complaint HDC 0902110 (Feb 2010) published on the HDC website in 2012 found breaches of the Health and Disability Consumers Code Right 4 (1) and Right 4 (2). Prior to the certification audit (November 2012) the DHB asked the auditors to verify improvements following the HDC investigation. The auditors had difficulty in verifying improvements due to the lack of an audit trail of improvement.

HDC 09/02012 (May 2010) – no further action by HDC.

Current Complaint: HDC C13HDC00010

4. Inspection Team

The inspection was undertaken by XXX XXX, Senior Advisor, HealthCERT, XXX XXX, Senior Advisor, HealthCERT, Ministry of Health, and XXX XXX, Gerontology Nurse Specialist, Auckland DHB, under delegated authority of the Director-General of Health.

5. Inspection Methodology

The following methodology was used during the inspection:

- Interview with XXX XXXClinical Nurse Manager.
- Interview with Maria McFarlane, Diversional Therapist.
- Interview with one Registered Nurse
- Interview with five Caregivers
- Interview with Cook
- Interview with one resident
- Observation of residents
- Physical inspection of premise / equipment
- Review of Clinical Records
- Review of policies and procedures

6. Inspection Limitations

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

7. Entry Meeting

On arrival at the premises, 19 Woodward Road, XXX XXX Senior Advisor, HealthCERT, and XXX XXX, Senior Advisor, HealthCERT, and XXX XXX, Gerontology nurse specialist, met with the Clinical Nurse Manager, (XXX XXX) who identified herself as being in charge at the time as the manager was away on annual leave. The purpose of the visit was explained and a letter addressed to XXX XXX (the provider's nominated contact person) outlining the complaint and the authorisation to undertake the unannounced visit was given to the Clinical Nurse Manager in his absence. A copy of the Director-General of Health's delegation was shown to the Clinical Nurse Manager and it was explained how the

inspection would be undertaken.

8. Inspection Findings

Findings have been reported against the following standards:

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

No	Findings	Relevant Standard/Criterion	Required Corrective Action/s
1	**1.1 Consumer Rights – Complaints management** At the time of the inspection, the provider was unable to provide a complaint's register, detailing all complaints and dates and actions taken.	HDSS 1.13, / 1.1.13.1	Provider is able to evidence that they have a system to record and resolve complaints in accordance with relevant legislative requirements.
2	**1.2 Organisational Management – Human Resource** The organisation at the time of inspection was unable to provide evidence that all staff on the dementia unit roster have completed the national standards in dementia care as per the Age-Related Residential Care agreement (E4.5).	HDSS 1.2.7 /1.2.7.5	Provider is able to evidence that staff are on the roster in the dementia unit have completed or are enrolled in the national standards in dementia care required in the ARRC service agreement (E4.5).
3.	At interview the clinical nurse manager confirmed that all staff had recently been moved from one area to another and the current staff on the roster in the dementia unit have not been orientated to the type of specialized care needed for the residents. Staff on the current roster also did not have the required unit standards specified in clause E4.5 (f). **1.2.8. Organisational Management** At the time of the investigation the organisation was unable to	HDSS 1.2.8/1.2.8.1	The provider must ensure a process is implemented to demonstrate that staffing needs are identified and changed as the result of changes in clients' care needs and or levels of care.

	demonstrate how changes in the number of patients in each care level were identified and managed. This was also identified at the last audit as a moderate partially attained finding with a six month time frame for a corrective action. This has been reviewed and as a result of staff changing areas without specific training or familiarisation, the time frame has been changed to one month.		
4.	**Continuum of Service Delivery** The medications management policy (July 2012) requires all health care assistants who administer medications to complete and pass an annual medication competency test. Staff have been identified as not completing medication competency prior to moving to either the rest home area or dementia area. This was a finding at the previous recertification audit. This has been reviewed and as a result of staff changing areas without specific training or orientation, the time frame has been changed to one month.	HDSS 1.3.12/1.3.12.3	The provider must ensure all service providers involved in medication management have completed an annual medicine competency.
5	**Safe and Appropriate Environment** The clinical nurse coordinator confirmed that training on fire and other emergency situations was covered during orientation. As staff have relocated into different areas, it is essential that they receive up to date evacuation training of the new area	HDSS 14.7/1.4.7.1	The provider must ensure that all staff receives training to respond to identified emergency and security situations, including fire evacuation procedures.

	they are working in. This criterion was identified as partially attained at the previous audit with a corrective action time frame of three months. As the staff relocated post audit this time frame has now been reduced to two months.		
6.	**Restraint Minimisation and Safe Practice.** The service had evidence that education was conducted on prevention and de-escalation techniques for challenging behaviour. However, ongoing education is not evidenced which includes the service's restraint definitions, the service's enabler use policy, the service's responsibility when restraint is used and alternatives to restraint. As the staff relocated post audit, this time frame has now been reduced to two months.	HDSS 2.1.1/2.1.1.5	The provider must ensure that on-going education is conducted on restraint minimisation and safe practice.

9. Summation Meeting

Present: XXX XXX, HealthCERT, XXX XXX, HealthCERT, XXX XXX, Nurse Specialist (DHB), XXX XXX, Director of Nursing (DHB), XXX XXX, Health of Older Persons manager (DHB).

XXX XXX 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.

Key Issues raised at the summation were:

- Very little evidence of progress being made towards the corrective actions from the certification audit undertaken in November 2012.
- Lack of staff training in the dementia services
- Lack of consultation with staff in relation to education/familiarisation requirements prior to moving to other areas.
- The use of communication/note books for staff containing personal health information of residents
- Assessment, care planning and evaluation issues

- Medication management issues
- Scopes of practice of caregivers
- Continence assessments were viewed in the files which did not meet the standards of good continence management. The comments in the assessment did not look at the aetiology of the problem, reversibility or any other conservative management options. The assessment only documented the colour of the pad prescribed (blue or yellow).