Final Inspection Report

Arlen Carter - Bermuda House

Date of Inspection: 10 September 2012

Contents

Executive Summary

HealthCERT received information from Canterbury District Health Board (DHB) regarding four anonymous complaints received between July and September 2012 about the standard of care provided by Arlen Carter to residents at Bermuda House.

The complainants' allegations related to: inadequate clinical oversight of residents including RN assessment after falls or incidents; residents are not referred to a GP when required; medication management; lack of formal systems for the registered nurse (RN) role; lack of clinical and quality management systems particularly regarding investigation or analysis following incidents/accidents; resistance to consult with specialist services for reassessment of residents or to seek specialist advice.

In response to the complaints, the Health of Older Persons DHB team visited the facility on 16 August 2012 to go through the complaints with management. Strong concern was expressed by the DHB team regarding findings and a follow up visit was arranged for the next week.

As part of the complaints process, the GP, Pharmacist and Older Persons Health Support Services (OPHSS) were contacted to obtain a wider opinion, by the DHB team. The GP stated there was likely some issues with Arlen's clinical management but advised he thought it was the responsibility of the DHB to make a decision about her ability to provide appropriate clinical care. The Pharmacist was happy with systems in place and did not raise any concerns. She did state that medication is usually arranged by a HCA or the assistant manager. No concerns were raised by OPHSS.

The DHB team revisited Bermuda House on 23 August 2012 to focus on clinical care of residents and this visit raised concerns regarding progress being made with regard to clinical oversight of resident care at Bermuda House

HealthCERT undertook an unannounced inspection at Bermuda House on 10 September 2012 in response to the complaints received, and at the request of Canterbury DHB, to determine whether health care services provided by Arlen Carter were being provided in compliance with section 9 of the Health and Disability Services (Safety) Act 2001 (the Act). That is, a person providing health care services of any kind must do so while meeting all relevant Health and Disability Services Standards.

The unannounced inspection identified areas of non-compliance with the standards relevant to the allegations in the complaints. There were 30 partially attained criteria against the relevant standards, with three standards (medication, quality and risk management) not met. These findings were in the areas of: Informed consent; privacy; complaint management; governance and clinical management; staff orientation and training; staffing levels and skill mix; quality and risk management; assessment and evaluation of care; provision of activities; medication management; nutrition and food management; maintenance and equipment; restraint management; and infection prevention and control.

Due to the insufficient clinical oversight and escalation of risk for residents, the DHB were requested to undertake further clinical assessment of residents and if there was due cause following this to have an immediate appointment of a temporary manager. Following re assessment of two residents, the DHB had appointed a temporary manager to ensure clinical oversight and safety for residents.

The complainants' allegations of:

- inadequate clinical oversight of residents including RN assessment after falls or incidents;
- residents are not referred to a GP when required;
- poor medication management;
- lack of formal systems for the RN role;
- lack of clinical and quality management systems particularly regarding investigation or analysis following incidents/accidents; and

- resistance to consult with specialist services for reassessment of residents or to seek specialist advice

were in parts substantiated as per the findings listed within the report.

Arlen Carter must complete the required improvements to ensure compliance against the Health and Disability Services Standards. Ongoing monitoring will be undertaken by Canterbury DHB in conjunction with the Ministry of Health.

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.

Previous Complaints

The provider has a three year certification due to expire in December 2012. At the certification audit in December 2009, there were 11 partial attainments against the Health and Disability Services Standards (SNZ 8134:2008), found, of which four were rated moderate risk.

The unannounced surveillance audit carried out in August 2011 found 15 partially attained criteria, with five of these being recurring issues. Eleven of these partially attained criteria were rated a moderate risk. It should be noted that not all PAs from the certification audit were formally re-audited at this surveillance audit. Canterbury DHB has worked with the provider to progress these findings.

The complaints raised in 2011 initiated a DHB Issues Based Audit in September 2011.

The key findings and recommendations from the Issues Based Audit September 2011 were:
- Involvement and communication with family needs to be improved and documented
- Dietician to review the menu and storage/preparation of food
- Accident and incident forms to be completed for all incidents
- Utilise incident and accident data for quality improvement and risk analysis
- Complaints policy must be adhered to and verbal complaints must be documented
- Staff appraisals to be undertaken
- Staff meetings to be held and documented
- Staff education to be held and documented
- Clear lines of responsibility be defined in clinical and non-clinical areas
- RN to complete clinical review policies and procedures
- Appropriately qualified person lead the quality program

Canterbury DHB worked with the provider to progress these findings.

Service Description

Bermuda House provides Aged Residential Care Rest Home Dementia services. The occupancy and capacity is outlined below:

Area	Occupied	Capacity
Hospital	0	0
Rest Home	0	0
Dementia	14	8
Day Care	(1)	
Total	**14**	**18**

Reasons for the inspection

The purpose of the inspection was to determine whether health care services being provided by Bermuda House 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;*

(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 [redacted], Senior Advisor HealthCERT and [redacted] Senior Advisor HealthCERT, under the delegated authority of the Director-General of Health.

Methodology

The inspection was conducted to investigate the complaints made to HealthCERT 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
- Observation: during facility tour 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 audit process.
- Clinical Notes review: a sample of six residents' notes from the facility were audited, using tracer methodology.

Limitations

The scope of the inspection was limited to the issues raised in the complaints, and widened in response to observations made on site.

Entry Meeting

The HealthCERT inspection team presented at the facility at 08:30am initially meeting the senior Health Care Assistant (HCA), who contacted the Manager by telephone. The letter of introduction was read to Ms Arlen Carter as she was unable to attend the facility. Ms Carter immediately contacted the assistant manager who did arrive promptly at the facility. The senior HCA was spoken to by Ms Carter and informed of the reason for the inspection. On the arrival of Ms Butterworth the entry meeting was held.

Present: [redacted], Assistant Manager [redacted], Senior Advisor HealthCERT and [redacted] Senior Advisor HealthCERT. It was noted that Ms Carter joined the meeting towards the end.

The introduction meeting covered the following points:

A copy of the letter of introduction addressed to Ms Arlen Carter was provided to her at 09:20am.

A proposed agenda for the day was discussed that included 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.

Summation Meeting

A summation meeting commenced at 16:00 and was attended by [redacted] Assistant Manager, [redacted], Senior Advisor HealthCERT and [redacted], Senior Advisor HealthCERT, [redacted] Planning and Funding DHB, [redacted] DHB, and [redacted] DHB. It was noted that Ms Carter was not available to attend the meeting. She did arrive at the end of the meeting.

The Senior Advisor 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.

A verbal summation of provisional findings was presented as follows:

Consumer Rights

1. Standard 1.9 Open Disclosure, not documented.

2. Informed Consent, EPOA not documented, Advanced Directives not following required standard, Not for Resuscitation forms signed by relatives.

3. Standard 1.13 Complaints, Time frames of policy are not being met and there are no outcomes or improvements for staff learning. Complaints had not been acknowledged or addressed, complaint register, no entries regarding resident issues for this year; however there is the attempt to start a register.

Organisational Management

1. Standard 2.1 The governance of the facility and clinical management needs clear definition as to responsibility and accountability for provision of service. In the absence of the Manager the role is filled by the Deputy Manager who has no clinical background.

2. Standard 2.3 Quality and risk at this facility is not being managed.

3. Standard 2.4 There are no corrective actions or improvements occurring from adverse events.

4. Standard 2.7 There has been no staff education since March 2012 inclusive of compulsory training.

5. Standard 2.8 HCA hours are adequate however, HCAs are also undertaking meal preparation and kitchen duties. There is insufficient RN cover for residents (the Manager has a dual role), as evidenced in the lack of RN input into progress notes, and reassessment. SNZ HB 8163:2005 notes there should be a minimum of two hours per week for each rest home resident. The Manager covers as the RN for the facility and there is another RN employed for six hours per week to write care plans, a possible 26 hours per week if the Manager uses half her time as the RN. The Deputy Manager is non-clinical.

Continuum of Service

1. Standard 3.3 Although initial assessments are carried out for residents, these are not being consistently reviewed and updated. Resident/family is not evident in the development of care plans. Assessments for pain, continence and behaviour management are not carried out routinely for residents.

2. Standard 3.5 Care plans are in place but are only reviewed at the required six monthly interval and do not reflect changes in acuity or events requiring short term plans. There were three residents noted at the inspection that require reassessment due to changing physical needs and acuity, there has been no on-going referral to NASC, dietician, or nurse specialists for residents at this facility.

3. Standard 3.7 Activities are not met, reassessments are not carried out. The diversional therapist is also the Deputy Manager and has been functioning as a HCA to cover shifts that have been vacant inclusive of night shifts. This has meant that she has been unable to carry out both roles.

4. Standard 3.12 The medication standard is not being met, staff competencies have been being carried out by the Deputy Manager (non-clinical) who has not had medication competency check. Storage of medicines is within an open cupboard within an open kitchen. RN competency for medication has not been carried out, and the Medicines Care Guides for Aged Care are not being implemented to support good practice.

5. Standard 3.13 The menu plan is not followed, issues regarding food being prepared hours ahead of time and no monitoring of food temperatures. The kitchen cleanliness was poor. The kitchen is still using the summer menu. Food storage practice is poor, not labelled and dated, stored on the floor etc. It was noted in the weight notebook that five residents had had weight loss of between 1 and 4kg over the last two months, with one resident not having had GP or dietician referral due to poor appetite and refusal to eat at times with weight loss.

   The Dietitian report advice of 2011 has not been followed with regard to providing increased milk, whole grain bread and protein drinks.

Safe and Appropriate Environment

1. Standard 4.7 There were insufficient food and water supplies for an emergency. The facility external garden areas are not safe for residents to negotiate unaccompanied. The fire assembly points need to be reassessed, as they are external and have no emergency egress.

Restraint

1. There has been no restraint training for staff or training in management of challenging behaviour. There is no consent for the bed sides currently in use.

Infection Prevention and Control

1. The general dirty state of the kitchen and cross infection of staff working across different roles is not accounted for. Although statistics on infections are monitored there is no evidence of corrective actions or improvements occurring from these.

2. It was stressed that these findings were provisional only, however they raised concerns regarding the safety of residents in this facility. There was a need for immediate clinical oversight of resident care and assessment as well as medication management and nutritional management.

3. The Advisor confirmed that there would be findings against the Health and Disability Services Standards as per the following table:

Inspection findings

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

Consumer Rights

Standard/ Criteria	
1.1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.	**Finding: Partially Attained** There were a number of shared rooms throughout the facility that had a curtain on a wire across the room but a strong lack of evidence that this was utilised when both residents in the room at the same time. Although there were curtains these were tied back with furnishings and not used by staff. Commodes were open and there was no privacy for residents in these shared rooms. Residents in double rooms were observed still sleeping with these conditions evident. Staff were observed later taking residents to the bathroom from their beds without using the curtains to give privacy during this process. **Corrective Action Request:** Ensure the service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.
1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	**Finding: Partially Attained** A tracer methodology of a resident who fell and fractured her neck of femor on 9 July 2012 and had facial skin tears and extensive bruising to face and jaw. There was no evidence of relatives having been advised under the open disclosure process. They were notified on 17 July when the resident was seen by the GP and an x-ray was ordered confirming the fracture and she was admitted to hospital. In July there were seven documented falls (no documentation available for August). None of these incidents had confirmation of notification of relatives either within the incident accident form or the residents' notes. **Corrective Action Request:** Ensure that all residents' family are informed of any error or adverse event occurring.
1.1.10.1 Informed consent policies/ procedures identify: (a)Recording requirements; (b) Information (including documentation) to be provided to the consumer by the service;	**Finding: Partially Attained** Resuscitation status (Not For Resuscitation or for resuscitation) forms have also been signed by relatives. Advanced directives have been signed by relatives. Admission agreement that does not comply with District Health Board Aged Related Residential Care Services (ARRC) agreement D13.3. **Corrective Action Request:** Ensure that advance directives are signed only by residents deemed competent to do so. Review process and policy regarding resuscitation and advanced directives to ensure they conform to legal requirements Ensure that admission agreements are compliant with the ARRC.

1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	**Finding: Partially Attained** There is no clear and responsive process for dealing with complaints. The manager stated that complaints are dealt with verbally if they occur, none had occurred for 2012. There was no quality and risk management regarding complaints leading to quality improvements and outcomes for residents and staff. **Corrective Action Request:** Ensure that the complaints process is documented and complies with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Ensure that the complaints process has outcomes based feedback to staff. Ensure that the complaints process leads to quality improvements and outcomes for residents and staff.
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 register that has been kept up to date for 2011 but there are no entries at all for 2012 when there have been known to be complaints. The Health of Older Persons DHB team visited the facility on 16 August 2012 to go through the four complaints received by them regarding the facility with management. There is a second complaints policy called minor complaints which are not monitored. **Corrective Action Request:** Ensure an up to date complaints register is maintained that includes all complaints, dates, and actions taken, including those of a minor nature.

Organisational management

Standard/Criteria	
1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.	**Finding: Partially Attained** The governance of the facility and clinical management is not clearly defined as to the responsibility and accountability for the provision of service. Although the facility has a clinical manager, this dual role has resulted in an escalation of clinical risk for residents as there is insufficient time allocated to clinical oversight. **Corrective Action Request:** Ensure that the roles of governance and management are clearly defined.
1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.	**Finding: Partially Attained** The assistant manager is non-clinical and has no experience in aged care management. The assistant manager has not met the required 8 hours minimum of professional development related to managing a rest home. Part of her role is to sign off the medication competency for Health Care Assistants (HCA) although she herself disclosed at interview that she has not had a medication competency. The assistant manager is also the senior person on call at the facility for HCAs. **Corrective Action Request:** Ensure the assistant manager receives professional development activities related to managing a rest home. Ensure that the assistant manager role job description clarifies boundaries regarding management verses clinical responsibilities.

1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.	**Finding: Standard not met.** The quality and risk management system was evidenced to not have been maintained and as per the surveillance audit finding (August 2011), there was no clearly defined quality plan and no process to measure achievement against the quality and risk management plan. The standard has not been met. There are no incident and accident forms completed for falls that have been documented in care plans. There was no evidence provided on request of meetings for staff to discuss relevant incidents or to ensure preventative actions are taken with learning outcomes for staff. **Corrective Action Request:** Develop a quality and risk management system which is understood and implemented.
1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system. This shall include, but is not limited to: (a) Event reporting; (b) Complaints management; (c) Infection control; (d) Health and Safety; (e) Restraint minimisation.	**Finding: Standard not met.** There is no documented evidence of quality meetings for this year. HCA confirmed there had not been any meetings this year related to quality or provision of services. There had been one meeting which was a debrief following an August DHB visit. The HCA stated no record of this meeting was available. **Corrective Action Request:** Ensure that regular meetings are held to discuss key components of service delivery are explicitly linked to the quality management system.
1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	**Finding: Partially Attained** Incident/accident data are not collated and analysed, identifying opportunities for improvement at a collective level does not occur. Behavior incidents are currently not reported using incident/accident forms. On the day of the audit one resident was observed to physically assault another resident. No incident form was completed, no behavior chart was completed. Staffs stated they were unsure how to manage the resident with aggressive behavior. This was observed on the time of occurrence. Incident accidents reported: seven reported by staff for July, (falls) no recordings for August and September. There was no evidence of family notifications, no outcome focused Quality and Risk Management in place, no evaluations if any actions taken, no preventative aspects considered or actioned. **Corrective Action Request:** Ensure that incident/accident data are documented, collated and analysed to identify service shortfalls and opportunities for improvement.
1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers	**Finding: Partially Attained** There was a new staff member recently employed. There was no police checking or reference checking on file. There were no orientation plans evidenced, as having been signed off and fully completed within the staff personnel files. At interview a HCA stated that new staffs were shown what to do by other HCAs. **Corrective Action Request:** Ensure appropriate reference checking is undertaken to verify skills and qualifications. Ensure that an orientation plan for new staff is implemented and completed.

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** There is an education plan for 2011/12. A number of scheduled sessions have not taken place and the service has identified that training is an area requiring improvement. The service is reliant on a consultant carrying out the education and this person has not been available for 2012, as planned. There has been no replacement education for staff. There has been no abuse and neglect training. There has been no restraint training (although one resident had a cot side insitu), or management of behavior of residents with dementia, (several residents had challenging behavior). Documents show that there had been two education sessions in 2012, in March (fire) and one other in April. This was confirmed at interview by the assistant manager and HCAs. **Corrective Action Request:** Ensure that the in-service training plan is fully implemented to include all required topics.
1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	**Finding: Partially Attained** There is no evidence of a Staff Skill mix policy. There is a registered nurse that works six hours per week on weekend days only, to ensure that care plans are compliant with policy, This was confirmed at interview with the assistant manager and staff. There was confirmation regarding staffing, HCA hours are within the SNZ HB 8163:2005 Guidelines, and the ARRC Agreement with the DHB. There was no concern regarding there being only one HCA on night duty as there was a flat upstairs and it was stated that the boarder (RN) living there was available if required. RN hours are not meeting the SNZ HB 8163:2005 Guidelines, even taking into consideration the manager's dual role (approximately 20 hours estimated) per week. **Corrective Action Request:** Develop a staff skill mix policy to demonstrate how the facility is managed in accordance with ARRC agreement, D.17.3 (e).
1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.	**Finding: Partially Attained** The progress reports are kept out of the residents files and reported on separately. They are not always documented on a daily basis, as evidenced by review of six files, five of which had had progress reported on last on the following dates 20 August; 26 August; 28 August; 3 September and 5 September. There were three examples where residents required close monitoring in relation to short term needs for which no progress reporting was evident. **Corrective Action Request:** Ensure the progress notes are kept in residents file and reported on at least once a day, or more frequently if there are changes to acuity.
1.2.9.10 All records pertaining to individual consumer service delivery are integrated.	**Finding: Partially Attained** Progress notes, medication order charts, and incident accident reports were all in separate files. Weight recordings were in both the file and a separate log book, not all had been transferred from the log book to the residents' files. **Corrective Action Request:** Ensure all records pertaining to individual consumer service delivery are integrated.

Continuum of Service Delivery

Standard/ Criteria	
1.3.3.2 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is developed with the consumer, and where appropriate their family/whānau of choice or other representatives as appropriate.	**Finding:** Not all relevant assessments are carried out at admission; a resident suffered from osteoarthritis and had been suffering discomfort of joints for long periods. There was no initial pain assessment and no further assessment of pain. Residents known to have aggressive outbursts, had no assessments or behavior monitoring charts. Although residents had continence needs there were no continence assessments within resident files, to determine requirements for their needs. It was evidenced through observation and also staff interview that residents were using commodes at night and had kylies to absorb moisture on their beds. Sheets of plastic and towels were placed on the floor between the bed and the commode to absorb leakage during this transition. Six of six care plans did not document on the care plan who had been involved in the care planning process. **Corrective Action Request:** Ensure that relevant assessments are carried out on admission, as a part of the care plan development.
1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	**Finding: Partially Attained** Care plans were well written and had been evaluated, but did not contain outcomes from assessment tools if used to ensure that interventions for care staff were documented to achieve outcomes for the residents. Nutritional supplements were not offered to a resident with significant weight loss. There was no evidence of use of the Liverpool Care Pathway or referral to palliative care teams where indicated. Residents known to have aggressive outbursts had no reference to guide staff in managing challenging behaviour or behaviour monitoring charts. Although residents had continence needs there were no continence guides within resident care plans to assist staff. There were continence products, no continence assessments had been carried out and residents were using commodes and kylies (absorbent draw sheets) at night and had towels and plastic on the floor at night due to incontinence. Two residents who were on bed rest had no management plans in place to prevent pressure areas in their care plans. There plans were up to date but had not been altered to reflect the changes in acuity from mobile to bed rest. One resident was a diabetic and the nutritional plan had not been amended to address his current acuity level. There were no clinical instructions for staff regarding his immobility and skin integrity or position for a chest infection. **Corrective Action Request:** Results from assessment tools utilised are to be documented in the care plan and interventions reflect the support/assistance required to meet goals and have desired outcomes for residents.
1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	**Finding: Partially Attained** The assistant manager also has the role of the diversional therapist (and an HCA when called upon). Initial activities assessments were carried out on admission. Initial assessments had not been evaluated and reassessed in six of six resident files.

	Corrective Action Request: Ensure that resident activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.
1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	**Finding: Partially Attained** There were five of 13 residents with weight loss between July to September 2012 from 1kg to 4kg. This was not written into care plans and no nutritional assessment or referral to a dietician had been made. Residents known to have aggressive outbursts had no behaviour monitoring charts or reference to behavior management in the care plans. There were no short term care plans in place for residents noted to have a change in condition requiring a change in care. Three residents were observed to be very frail and were referred for reassessment by the NASC. There were no short term care plans in place for these residents, and at interview the assistant manager and staff stated there were no residents. **Corrective Action Request:** Ensure that care plans are updated with guidance for staff where progress is different from expected. Ensure that residents are referred to appropriate other health and/or disability service providers.
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** Medications are stored in a cupboard in the open kitchen which had a broken lock, and are accessible to residents, staff and visitors. The main kitchen refrigerator had antibiotics and other medication stored in the door storage area. There was no separate refrigerator or separate storage box within the kitchen refrigerator. The staff was observed giving medications using the supply list from the pharmacy not the GP signed medication chart which was kept in a separate file. As breakfast was served between 0900 and 0930 hour's medications were administered at this time, with a three hour gap between this and the next medication administration at 12:30. Medication was not administered and stored in order to comply with legislation, protocols, and guidelines. This criterion requires that compliance with legislation, protocols, and guidelines, are followed. At interview the assistant manager and staff were unaware of the Medicines Care Guides for Aged Residential Care (2011) and were not following these protocols for safe management of medication. **Corrective Action Request:** Ensure that medication is administered and stored in order to comply with legislation, protocols, and guidelines. Ensure staffs are administering medication from a signed medication chart.

1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	**Finding:** There was no evidence of the RNs having medication competencies and all HCA deemed competent to administer medication had been assessed by a non-clinical assistant manager who did not have a medication competency herself. **Corrective Action Request:** Ensure that service providers responsible for medicine management are competent to perform the function for each stage they manage.
1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognized nutritional guidelines appropriate to the consumer group.	**Finding: Partially Attained** Evidence shows that five residents have had weight loss over the last few months. There has been no referral to a dietitian to review the individual residents affected. Although for one of these five residents referral had been made to a dietitian by email, this had not been followed up when there was no response. **Corrective Action Request:** Ensure that nutritional needs of consumers are provided in line with recognised nutritional guidelines.
1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	**Finding: Partially Attained** The kitchen area was dirty. The floor space around the cooker had not been cleaned for some time. There were three microwaves for heating meals stacked on top of each other and sharing plugs. The main meal of the day (evening) was plated and stored in the chiller, covered by plastic wrap but not dated having been cooked by the night HCA. The chiller was not keeping the correct temperature.as evidenced by the non-changing temperature gauge on the outside of the chiller. Other freezers and refrigerators in the area had recently been fitted with new functioning temperature gauges; however the chiller storing the prepared food had not been fitted with one of these new gauges. The kitchen was open to residents, visitors and staff to wander in and out. The dry food storage area was not compliant with the storage of dry goods as per the food safety legislation. Stored food was overflowing from the self and stored on the floor a mixture of sugar, flour, pumpkins and potatoes etc. **Corrective Action Request:** Ensure all aspects of food production, preparation, and storage; comply with current legislation, and guidelines.

Safe and Appropriate Environment

Standard/Criteria	
1.4.2.3 Amenities, fixtures, equipment, and furniture are selected, located, installed and maintained with consideration of consumer and service provider safety, needs and abilities	**Finding: Partially Attained** The kitchen was observed to be open to residents, visitors and staff to wander in and out. As there is only one HCA on duty at night and this is when the meals are being cooked for the next day, there is a high risk of residents wandering into the kitchen when it is unattended. At interview the assistant manager confirmed that she had been working as a HCA on night duty to cover a vacancy, and noted that there were times when she was called away from food preparation. It was observed while breakfast and lunch were being served the kitchen was left unlocked and unattended with hot food e.g. porridge cooking. There were three microwaves for heating meals stacked on top of each other and sharing electrical plugs. The provider had one air mattress in use and although there was another resident who was in need could not provide this equipment. One resident was observed to have this air mattress insitu while

	another two residents requiring similar prevention had normal mattresses insitu. **Corrective Action Request:** Ensure fixtures and equipment are selected, installed and maintained with consideration of consumer and service provider safety.
1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.	**Finding: Partially Attained** During a trial fire evacuation it was noted that the exit ramp was too steep for residents to safely manage unassisted to the safe area. **Corrective Action Request:** Ensure resident safety is maintained when using the external garden area.
1.4.3.3 Consumers, service providers and visitors are provided with adequate had washing facilities to ensure compliance with infection control policies.	**Finding: Partially Attained** Soap dispensers throughout the facility were empty. The senior HCA was advised at the time of the inspection that these containers were empty. These were not refilled throughout the course of the day. **Corrective Action Request:** Ensure consumers, service providers and visitors are provided with adequate hand washing facilities to ensure compliance with infection control policies.

Restraint Minimisation

2.2.3.3 The frequency and extent of monitoring of the consumer during restraint is determined by the risks associated with the consumer's needs and the type of restraint being used.	**Finding:** There is no restraint consent in place for a resident with bed-sides and no monitoring form in place, either within the file or in the separate progress note file, when asked the assistant manager was unable to locate these. **Corrective Action Request:** Ensure that restraint monitoring is documented.
2.2.3.6 Each service provider has an individual record of education and competency in relation to restraint minimisation and safe practice.	**Finding: Partially Attained** Restraint training, included challenging behavior and de-escalation techniques have not been given to staff since 2010, The next scheduled training for restraint is scheduled for November 2012, as per the other scheduled training postponed in 2012 the assistant manager was unable to confirm that this training would take place. **Corrective Action Request:** Ensure that all staff has restraint training, included challenging behavior and de-escalation techniques.

Infection Prevention and Control

Standard/ Criteria	
3.1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.	**Finding: Partially Attained** The manager is the infection control officer at Bermuda house There was no evidence of a job description for this role. There are no clear lines of accountability. The assistant manager was asked to provide this, due to the office being in disarray she was unable to locate this job description. **Corrective Action Request:** Ensure there is an up to date job description for the infection control officer.

3.1.3 The organisation has a clearly defined and documented infection control program that is reviewed at least annually.	**Finding: Partially Attained** There was no evidence of the infection control program having been reviewed since 2009. **Corrective Action Request:** Ensure the infection control program is reviewed at least annually.

Conclusion

The unannounced inspection was focused on determining whether the Health and Disability Service Standards being met with regard to the alleged complaints against this provider.

The following are the outcomes for follow up of progress towards the provider meeting requirements post these complaints being substantiated:

Resident Rights:

- the service did not respect the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times
- an open disclosure policy was not in place and resident's family were not informed of any error or adverse event
- process and policy regarding resuscitation and advanced directives, required review and policy was not being followed
- admission agreements were not compliant with ARRC agreement and there were no records of activated and signed EPOA
- the complaints process documentation is not compliant with Right 10 of the Code, has no outcomes based feedback to staff or process which leads to quality improvements and outcomes for residents and staff and complaints are not written in a register.

Organisational Management:

- the roles of governance and management are not clearly defined and there is insufficient clinical oversight
- the assistant manager receives no professional development related to managing a rest home, does not have a role job description that clarifies boundaries regarding management verses clinical responsibilities
- the service needs to develop a quality and risk management system which is understood and implemented
- there are no regular meetings are not held to discuss key components of service delivery are explicitly linked to the quality management system
- incident/accident data is not documented, collated and analysed to identify service shortfalls and opportunities for improvement
- staff pre-employment appropriate reference checking is not undertaken to verify skills and qualifications
- an orientation plan for new staff is not implemented and completed
- the in-service training plan is not fully implemented to include all required topics
- a performance appraisal timetable is not in place to ensure that all staff has an up to date appraisal
- there is not a staff skill mix policy to demonstrate how the facility is managed in accordance with ARRC agreement, 0.17.3.

Continuum of Service Delivery:

- residents are not always seen by a GP within 48 hours of admission as per ARRC D16.5e.
- the progress notes are not kept in the residents file and reported on at least once a day, or more frequently if there are changes to acuity.
- all records pertaining to individual consumer service delivery are not integrated.
- relevant assessments are not carried out on admission, as a part of the care plan development and care plans do not document who has been involved in the care planning/ review process.
- results from assessment tools utilised are not documented in the care plan and interventions do not reflect the support/assistance required to meet goals and have desired outcomes for residents.
- resident activities are not planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that is meaningful to the consumer.
- care plans are not updated with guidance for staff where progress is different from expected, and residents are not referred to other appropriate health and/or disability service providers.
- medication is not administered and stored in order to comply with legislation, protocols, and guidelines and staff are not administering medication from a signed medication chart.
- service providers responsible for medicine management are not competent to perform the function for each stage they manage.
- nutritional needs of consumers are not always provided in line with recognised nutritional guidelines.
- aspects of food production, preparation, and storage, do not comply with current food safety legislation, and guidelines.

Safe and Appropriate Environment:

- fixtures and equipment are not always selected, installed and maintained with consideration of consumer and service provider safety
- resident safety is not maintained when using the external garden area
- consumers, service providers and visitors are not always provided with adequate hand washing facilities to ensure compliance with infection control policies.

Restraint Minimisation:

- restraint monitoring is not documented
- staff have not had restraint training, included challenging behavior and de-escalation techniques.

Infection Prevention and Control:

- there is no up to date job description for the infection control officer
- the infection control program has not been reviewed at least annually
- there has not been an infection control education session provided by a suitably qualified person.

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: 1.1.3.1, 1.1.9.1, 1.1.10.1, 1.1.13.1, 1.1.13.3, 1.2.1.3, 1.2.2.1, 1.2.3.1, 1.2.3.5, 1.2.4.3, 1.2.7.3, 1.2.7.5, 1.2.8.1, 1.2.9.1, 1.2.9.10, 1.3.3.2, 1.3.5.2, 1.3.7.1, 1.3.8.3, 1.3.12.1, 1.3.12.3, 1.3.13.1, 1.3.13.5, 1.4.2.3, 1.4.2.6, 1.4.3.3, 2.2.3.3, 2.2.3.6, 3.1.1, 3.1.3, as identified in the Inspection Report must be submitted to the Canterbury District Health Board by 30 November 2012.

2. HealthCERT may elect to carry out a verification audit in relation to these corrective actions.

3. 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 - unable to be provided
- Rosters (last month and this month) -provided
- Abuse and Neglect Policy - provided
- Management of Challenging Behavior Policy - unable to be provided
- Complaints management policy - provided
- Complaints records for the last two months - provided
- Staff training records and in-service training program - provided
- List of staff with current first aid certification - unable to be provided
- List of staff with current medication competency - provided
- Quality and risk management plan - unable to be provided
- Incident and accidents records for the last two months - provided one month only
- Minutes of staff meetings - unable to be provided
- Minutes of quality meetings - unable to be provided
- Resident files -six randomly selected
- Completed resident satisfaction survey - unable to be provided.