Final Inspection Report

Bupa Care Services NZ Limited
Cedar Manor Rest Home & Hospital

Date of Inspection: 4 April 2013

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

Contents

Provider details

Provider:	Bupa Care Services NZ Limited
Premise:	Cedar Manor Rest Home and Hospital
Contact Person:	Sue Forster, Manager
Internal File Ref:	G00178-C07
Inspection Date:	4 April 2013

Executive summary

The Ministry of Health received a complaint from Ms B on 18 March 2013 about the standard of care provided to her father, Mr A, at Cedar Manor Rest Home and Hospital. The complaint raised concern that Bupa Care Services NZ Limited 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 Cedar Manor Rest Home and Hospital.

Ms B alleged that:

- care plans were poor, with no reference to Mr A's individual healthcare needs
- there had been no family involvement with care planning
- Mr A had lost weight since admission
- soiled linen was left on Mr A's bed and the room was dirty
- there was poor personal grooming, and Mr A's clothes were dirty and stained
- socks and slippers were missing for days, leaving Mr A with bare feet
- falls had occurred with no open disclosure to family
- there had been no review of medication, even following family asking for XXX dosage to be reviewed
- there was poor Infection Prevention and Control practice - staff left the afternoon tea trolley to empty a resident's catheter and then returned to food service without washing their hands
- Mr A had a continuously leaking XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX
- there was no response to a written complaint about the above issues.

Summary of findings in respect of the complaint

Care Plans

There was a well-developed and documented assessment process. Eight out of eight care plans reviewed, including Mr A's, demonstrated that assessment, planning, and evaluation of care plans undertaken by the registered nurse were completed. The audit that was undertaken in January 2013 found that timeframes for the care planning were not always met and this finding has yet to be corrected. There was also evidence of the GP having assessed residents at three monthly reviews or as necessary. A registered nurse undertakes the assessments on admission in the rest home, dementia unit and hospital, with the initial support plan completed within 24 hours of admission. Mr A's care plan noted XXX and XXX issues, although these had been added during his stay and not on admission.

Outcome – not substantiated

No family involvement with care planning

In the eight files reviewed, family were, where appropriate, involved from the time of admission and continued to be involved when there was a review of the lifestyle care plan. Assessment information was gathered from a variety of sources, including the resident, their family and allied health professionals, this was evident in Mr A's file.

Mr A's file showed that the family had written specific instructions about the line of communication to be taken with family members. Ms B (complainant) was not listed as the first or second person to call for information or to communicate with.

Outcome – not substantiated

Weight loss since admission

The file review showed that Mr A had lost weight from the time of admission on 21 September 2012. His weight had decreased from 61.5 kg in October 2012 to 54.8 kg on March 2013. A short term care plan was instigated on 5 March 2013 that included sustagen drinks, larger meals and, in discussion with the GP, a referral to the Dietician.

There were policies for nutritional assessment and management. There was evidence that additional nutritious snacks were available over 24 hours for all residents. Dementia care residents have access to snacks between meals. Residents' weight charts were used to identify weight stability. Where weight loss was identified, residents were placed on a weekly weight chart. This included Mr A. Supplements were available. In one of the eight files reviewed, the resident with weight loss also had a short term care plan. Mr A stated there was enough food at meal times and that he did not attend activities regularly. This issue was not substantiated as there was a weight management plan activated.

Outcome – not substantiated

Soiled linen left on bed and dirty room

On the day of the inspection there was no evidence of any soiled linen left on any of the residents' beds. The rooms appeared to be clean and tidy. There were damaged skirting boards and door frames in some areas but this was identified in an audit in January 2013 and a corrective action was raised at this time. Rooms sighted during the audit were highly personalised and looked clean and uncluttered. This included Mr A's room.

Outcome – not substantiated

Poor personal grooming

On the day of the inspection Mr A was tidily dressed in his own clean clothes and had footwear on. The amount of clothing was appropriate for the day. Mr A's hands and nails were dirty and staff were asked to attend to Mr A. Staff responded as requested.

Mr A XXX XXX XXX XXX XXX XXX when he was spoken to on the day of the inspection. He explained that there were still issues with XXX XXX and complained that staff did not answer the bell quickly

Outcome – partially substantiated

Socks and slippers missing for days

On the day of the inspection Mr A had socks and footwear on.

Outcome – not substantiated

Falls occurring with no open disclosure

On examining Mr A's file and a sample of other resident files there was evidence that the family who were recorded as being the first and second to call had been notified of events in an appropriate timeframe. The complainant was not the first or second person to call in relation to Mr A. The communication sheet in Mr A's notes noted records of conversations with the listed family members after events. The documentation in respect of a fall on 9 March 2013 showed appropriate treatment and care was delivered – a skin tear occurred and the wound was mapped, neurological observations were carried out regularly, the registered nurse and enrolled nurse had noted in the progress notes a daughter on the call list was informed and a short term care plan was developed post fall. Open disclosure to the nominated family members was occurring. Whilst the complainants contact details were in the resident's file, the complainant was not the nominated first contact.

Outcome – not substantiated

No review of medication following family request

XXX was listed as one of the diagnoses on Mr A's admission. There was evidence of changes by the GP (both reductions and increases) in Mr A's XXX medication. The care plan also highlighted the need to increase XXX in Mr A's diet. The daily progress reports showed ongoing issues with XXX and XXX XXX, and this was one area that needed a close review with concerted effort by staff to assist the resident to manage this problem. There was no documented evaluation of the effect of the changes made to medication doses.

Outcome – not substantiated

Poor Infection Prevention and Control

On the day of the inspection, staff were observed carrying out normal duties, there was no evidence to suggest there were any poor infection control practices.

Monitoring is the responsibility of the infection control coordinator.

There is an infection control register in which all infections are documented monthly. Infection control data is collated monthly and reported to the infection control committee. Individual infection report forms are completed for all infections. This is kept as part of the resident files.

Outcome – not substantiated

Continuously leaking XXX XXX XXX

Mr A had XXX XXX XXX XXX XXX XXX. There was no evidence of the XXX leaking on the day of the inspection. The notes showed that there had been a history of XXX XXX XXX XXX and Mr A was admitted to hospital as a result XXX XXX XXX. There was evidence in the notes of regular XXX XXX XXX XXX occurring.

Outcome – not substantiated

No response to a written complaint

A meeting with the complainant and the senior management staff of Bupa had occurred on 20 March. A copy of the minutes for this meeting was provided to the HealthCERT advisors on the day of inspection.

Conclusion

Of the eleven allegations raised by the complainant, the inspection resulted in two partially substantiated aspects of the complaint. The findings were in relation to the Health and Disability Services Standards (NZS 8134:2008). Bupa Care Services NZ Limited was not fully compliant with the standards in relation to personal grooming, and evaluation of a prescribed XXX. Bupa Care Services NZ limited is required to address the corrective actions outlined in section 7. Ongoing monitoring will be undertaken by the Ministry of Health in conjunction with Bay of Plenty District Health Board.

On inspection, the issues identified at an audit in January 2013 were being managed. There was evidence of an action plan to address the required corrective actions. However on review of the clinical records during the inspection, some issues identified at the audit remained outstanding.

Background

Bupa Care Services NZ Limited – Cedar Manor Rest Home and Hospital has a two year certification, expiring 31 January 2015. A full certification audit in January 2013 identified eight partial attainments against the relevant Health and Disability Services Standards, three rated moderate risk, relating to care planning and medication. Four of the eight partial attainments were recurring from the previous spot audit, (corrective action planning, care planning and medication). This was the second two year certification period for this provider.

Previous Complaints known by the Ministry of Health

- May 2011: Substantiated complaint.
- April 2012: Substantiated complaint.
- June 2012: Notification of reportable event under Section 31 of the Act.

Inspection team

The following methodology was used during the inspection:

- interview with Facility Manager
- interview with Clinical Nurse Manager
- telephone interview with General Manager
- interview with two care givers
- observation of residents
- physical inspection of premise / equipment
- review of clinical records
- review of policies and procedures

- interviews with residents.

Inspection limitations

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

Entry Meeting

The entry meeting was held with Sue Forster, facility manager, at 9.45 am. The facility manager was given the opportunity to read the letter of entry from the Ministry of Health and copies of the Director General of Health's delegations were shown. Ms XXX explained how the inspection would be undertaken.

Ms Forster was already aware of the complaint. A teleconference was held with XXX XXX, Director of Rehabilitation and Care Services, and Jan Tulloch, Regional Manager, to discuss a recent meeting that had taken place with facility staff and Bupa senior management, and the complainant and advocates, held on 20 March 2013. A copy of the letter sent 25 March 2013 by Bupa to the complainant was given to HealthCERT Advisors.

Inspection findings

Findings have been reported against the Health and Disability Services Standards 8134.1:2008

No	Relevant Standard/Criterion	Findings	Required Corrective Action/s
1	**Standard 1.3.5** Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	There was no evidence of a short term care plan for on-going issues of management of XXX for Mr A.	Ensure all identified issues have related interventions in a short term care plan.
2	**Standard 1.3.6** Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	The interventions were not specific in relation to Mr A's XXX issues. Documentation in the progress notes was inadequate.	Ensure there is adequate documentation that evidence progress towards meeting the desired outcome for the identified issues/problem.
3.	**Standard 1.3.8** Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	There was no consistent evaluation of the on-going XXX management issue by nursing and medical staff.	Ensure medication for bowel management is evaluated, reviewed and amended either when clinically indicated or by a change in the resident condition.

Meeting at end of inspection

Present: Sue Forster, Facility Manager; XXX XXX, HealthCERT; XXX XXX, HealthCERT; XXX XXX and XXX XXX , Bay of Plenty District Health Board, Health of Older Persons Portfolio Managers. Grainne Moss, Bupa Director of Care Services, participated via telephone.

XXX thanked facility personnel 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:

- nine of the eleven issues raised by the complainant were not substantiated at the inspection. Two issues were substantiated to some degree
- the two issues that were partially substantiated were related to the personal hygiene issues found on the day of inspection and in relation to the evaluation of the effect of medication changes.

Provider's response to draft report

The provider was given a copy of the draft report and asked to comment on any factual errors. A written response was received on 22 May 2013. The response was considered before this report was finalised. Some editing has been done to the draft report to better clarify some aspects of the findings.