Final Inspection Report

Liberty 2000 Limited
Kintala Lodge Rest Home

Date of Inspection: 21 March 2013

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

Contents

Provider details

Provider:	Liberty 2000 Limited
Premises:	Kintala Lodge Rest Home
Contact Person:	Nalini Singh
Internal File Ref:	WLI04
Inspection Date:	21 March 2013

Executive summary

The Ministry of Health received a complaint on 12 March 2013 via the Minister of Health which alleged Liberty 2000 Limited could have been in breach of its obligations as a provider certified under the Health and Disability Services (Safety) Act 2001 to provide services at Kintala Lodge Rest Home. The complaint was made by Ms A and related to the care provided to her mother, Mrs B, while a resident at Kintala Lodge Rest Home.

The complainant alleged that:

- her mother sustained multiple falls which resulted in injuries, including broken bones
- her mother had black eyes at various times, and staff could not explain how the injuries had occurred
- her mother lost a significant amount of weight
- her mother's personal cares were neglected
- staffing levels were inadequate.

As a result of this complaint, an unannounced inspection was undertaken by the Ministry on 7 March 2013 in accordance with sections 40, 41 and 43 of the Act. On the basis of evidence reviewed, aspects of the complaint related to incidents /accidents and weight loss were substantiated. Aspects related to personal cares and staffing were not substantiated.

The inspection identified five partially attained criteria against the relevant Health and Disability Services Standards. Liberty 2000 Limited is required to address the corrective actions outlined in section 6. On-going monitoring will be undertaken by the Ministry of Health in conjunction with Waikato District Health Board.

Summary of findings in respect of obligations as a certified provider under the Act

Under section 9 of the Act, a person providing health care services of any kind must do so:

(a) while certified by the Director-General to provide health care services of that kind; and
(b) while meeting all relevant service standards; and
(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 the Act.

Multiple Falls

Mrs B's clinical file indicated assessment and review of falls risk. Two assessments were in the archived file, one pertaining to locomotive ability and the other to balance. There was no overall rating of aggregated risk.

Although a falls assessment had been completed there was no falls prevention programme in place that would have alerted staff to the fact the resident had sustained previous falls. There were no interventions documented in the care plan to reduce the likelihood of falls reoccurring.

Adverse events were recorded in the resident's nursing notes. However, incident forms could not be evidenced.

Mrs B sustained four significant fractures in a 12-month period. The file did not contain copies of all the incident forms related to these fractures.

When the resident fell, the incident form was completed but not updated/reviewed to include undiagnosed fractures post the initial event. This led to a discrepancy in data collection when collating monthly adverse events.

There was no process to ensure incidents were managed effectively. Information gained from incidents and trend analysis should feed into the continuous improvement system for positive results for residents.

The Clinical Nurse Manager is a registered nurse and is responsible for co-ordinating and reviewing incident Reports. This includes the assessment and investigation of incidents, the identification of the appropriate action required, and documenting on the incident report any actions taken. The clinical nurse manager reports directly to the General Manager who is the owner.

Monthly clinical board reports had not been produced since August 2012, with the exception of October 2012.

The Clinical Nurse Manager was also responsible for the assessment, planning, implementation, evaluation and monitoring of resident care. Her duties included the supervision of all caregiving staff while on duty and the recording of resident care plans.

The provider has a responsibility to have structures in place to ensure that all its residents are provided with an appropriate standard of care.

Outcome – Substantiated

Unexplained injuries (black eyes)

Staff had witnessed Mrs B bumping into objects and surfaces. The assumption was made that Mrs B's facial bruising was caused by such incidents. Mrs B's care plan had not been updated to reflect the incidents that had occurred causing the facial bruising. There was no plan to identify ways to prevent or minimise such incidents to avoid or minimise injuries. In addition, there were limited processes in place to ensure the environment was safe and secure.

Outcome – Substantiated

Management of Weight loss

While there was initial assessment of needs and preferences in relation to the residents' nutrition and hydration there was no evidence of consultation with a dietician when weight

loss occurred.

A review of three resident files indicated a significant weight loss. The sample size was then increased.

A review of the weight management book noted that in the sample size of 13 residents, four residents had a weight loss over the past year of between 8.6 percent - 25 percent of their initial body weight. There was no evidence of dietician referrals for individual residents with an identified weight loss. The menu was last reviewed by a dietician in 2010.

There were four other residents on a prescribed nutritional supplement, only one remained under their admission weight, the other three residents had weight increases between 2 percent and 11 percent. There was no weight management programme or policy for identification of residents at risk of having or developing malnutrition or dehydration due to clinical or emotional issues.

Although all residents' weights were recorded monthly, this data was not analysed and therefore no evaluation was carried out to determine a pattern of weight loss affecting more than one resident.

In the case of Mrs B's weight loss, over her time at Kintala she lost 14.3 kg during her stay (25 percent loss over the twelve months). In her first month of admission she had a 6 percent weight loss and in three other months a weight loss of 3 percent or more occurred. No weight management programme or dietary supplement was initiated.

Outcome – Substantiated

Personal cares

Staff confirmed they took into account residents' choices in regards to independence, privacy, dignity, cultural and spiritual needs in planning and carrying out care. They also acknowledged that some residents at times may be difficult to manage when carrying out personal cares.

There was evidence of consultation with residents and/or representatives on individual residents' needs and preferences.

The provider could demonstrate staff had the knowledge and skills required for effective performance in relation to the provision of care in accordance with residents' needs and preferences.

Staff had appropriate qualifications relevant to the tasks they perform.

Care needs were met in a way which ensured the privacy, dignity and respect of residents.

Observations:

- residents' general appearance
- staff interactions with residents
- staff practices and availability of staff
- staff access to information on residents' needs
- quantity, storage and condition of goods and equipment such as medical stocks, continence aids, personal care items and mobility aids.

Outcome – Not substantiated

Staffing levels

The roster was reviewed for the last three months, and the Registered Nurse Hours were reviewed. There was one registered nurse, the Clinical Nurse Manager, who is employed 40 hours per week.

The Standards NZ 8163:2005 Indicators for Safe Aged Care and Dementia Care for Consumers provide recommended staffing hours for dementia services.

The care givers hours at Kintala Lodge Rest Home were above recommended hours by 30 per week, however in this unit staff were required to undertake additional duties of laundry, in the afternoon, which took them away from direct care. It is recommended that the provider reviews the laundry duties in the afternoon when often the overall needs of the residents may be higher.

It is recommended that the rostered registered nurse hours are reviewed against Standards NZ 8163:2005.

Outcome – Not substantiated

Background

Kintala Lodge Rest Home is owned by Liberty 2000 Limited. One of the Directors of the company is the on-site General Manager. The provider is currently certified for three years with a certificate due to expire 12 September 2013. The certification audit undertaken in 2010 resulted in one partially attained criterion of low risk.

Previous Complaints known by the Ministry of Health

There have been three separate complaints received at the Ministry of Health that have been investigated by the DHB and closed out. There have been no previous Health and Disability Commissioner complaints.

Inspection team

The inspection was undertaken by XXX XXX, Senior Advisor, HealthCERT, XXX XXX, Senior Advisor, HealthCERT, Ministry of Health, under delegated authority of the Director-General of Health.

Inspection process

The following process was used during the inspection:

- interview with Facility Manager
- interview with Clinical Nurse Manager
- interview with Registered Nurse
- interview with three care givers
- physical inspection of premise/equipment
- review of Clinical Records
- review of policies and procedures.

Inspection limitations

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

Inspection findings

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

No	Relevant Standard/Criterion	Rating	Findings	Required Corrective Action/s
1	**Standard 1.2.3** The organisation has an established, documented and maintained quality and risk management system that reflects continuous quality improvement principles.	Partially Attained	1.2.3.5 i. Monthly aggregation of data was not undertaken so outcomes were not able to be discussed at quality improvement and staff meetings. ii. Actions taken to minimise risk to individual residents were not recorded on corrective action plans. iii. There is no benchmarking of clinical indicators against other aged care providers iv. The monthly board of directors reports had not been completed for six months.	i. Collate and aggregate data to determine trends and once in place use trending information to implement strategies to mitigate clinical risk ii. Corrective action plans are implemented and evaluated. iii. Benchmark with other aged care providers iv. Board reports are prepared and presented monthly as determined by policy.
2	**Standard 1.2.4** All Adverse, unplanned or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whanau of choice in an open manner.	Partially Attained	1.2.4.3 Not all clinical events were reported through the incident and accident process, particularly injuries that had not been diagnosed at time of the incident.	Ensure adverse events are fully reported through the incident and accident reporting process.
3	**Standard 1.3.4** Consumers' needs, support requirements and preferences are gathered and recorded in a timely manner.	Partially Attained	1.3.4.2 There is no weight management programme, or rationale to determine actions should a resident have significant weight loss.	Develop a weight management programme that identifies residents at risk, and where weight loss has occurred, and ensure that appropriate referral and actions are taken.

4	**Standard 1.3.13** A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery	Partially Attained	1.3.13.1 A dietician review had not occurred since 2010. 1.3.13.2 Where residents had significant weight loss there were no direct referrals to dietician or GP.	Ensure a dietician review occurs every two years. Residents with identified weight loss must be referred to the appropriate external consultant for nutritional requirements.

Meeting at end of inspection

Present: XXX XXX, HealthCERT, XXX XXX, HealthCERT, XXX XXX, Health of Older Persons Manager (Waikato DHB). Nalini Singh, (Owner Manager) Dr Singh (Owner) Dr XXX XXX(General Practitioner), XXX XXX Clinical Nurse Manager.

XXX XXX thanked the 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 were:

- Twelve weight charts were reviewed and four residents were found to have had significant weight loss.
- No dietician review of menu since 2010.
- No intervention for those residents who had been identified with significant weight loss, and no referral to dietician.
- Risk monitoring and analysis including clinical risk management was not evident.
- Although data was collected each month there was no analysis of quality improvement.
- There was an identified short fall of Registered Nurse hours, in accordance with the Indicators for Safe Aged Care and Dementia Care for consumers.
- Clinical board reports were not available since August 2012 with the exception of one report produced in October 2012.
- No adverse event reporting to the district health board had been recorded.
- Incident and Accident forms that had been filled out did not match with corresponding injuries sustained by the complainant's mother (i.e. more falls noted in nursing notes and no incident forms filled out).
- Very high rate of falls.
- No specific falls prevention programme in place.

A written progress report that outlines all actions undertaken by the provider in relation to corrective measures against Health and Disability Services Standards 1.2.3.5, 1.2.4.3, 1.3.4.2, 1.3.13.1, 1.3.13.2 (as approved under section 13 of the Act) must be submitted to your District Health Board by 30 July 2013. 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.

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. Liberty 2000 Limited is required to undertake the above corrective actions within the specified timeframe. If the corrective actions are not achieved, the Ministry may take action in relation to non-compliance with the requirements of the Act.

The provider was given a copy of the draft report and asked to comment on any factual errors. Nalini Singh responded in a letter dated 28 May 2013. Ms Singh's comments were considered before this report was finalised. No changes were made to the draft report as a result of factual errors.