Final Inspection Report

Cressida Healthcare Limited –
Renaissance Rest Home and Private Hospital

Date of Inspection: 26 June 2012

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Executive summary

In June 2012, HealthCERT received information from Taranaki District Health Board (DHB) regarding four complaints about the standard of care provided by Cressida Healthcare Limited at Renaissance Rest Home and Private Hospital. The complainants' allegations related to: staffing levels, poor quality of food, food served cold, the laundry service, lack of cleanliness, call bells not working, lack of activities for residents, water temperatures, broken equipment, the external environment, and leaks in the roof and windows. The DHB asked HealthCERT to investigate the allegations.

HealthCERT undertook an unannounced inspection at Renaissance Rest home and Private hospital on 26 June 2012 to determine whether health care services being provided by Cressida Healthcare Limited 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 Health and Disability Services Standards.

The outcome of the unannounced inspection identified areas of non- compliance with the Health and Disability Services Standards, with 24 criteria partially attained.

These findings were in the areas of: Open disclosure, 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, cleaning and laundry services, maintenance and internal and external environment, and infection prevention and control.

The complaints were substantiated, with the exception of the call bell system which had been repaired following an urgent request from Taranaki DHB. Cressida Healthcare Limited must complete the required improvements to ensure compliance against the standards. Ongoing monitoring will be undertaken by Taranaki DHB in conjunction with the Ministry of Health.

Recent History

The provider had a provisional audit prior to purchase of the facility in January 2010. At this audit there were 15 partially attained criteria against the Health and Disability Services Standards, with improvements required.

The certification audit undertaken in February 2011 resulted in 32 partially attained criteria. The DHB then worked with the provider on improvement. The provider has a two year certificate, due to expire on 9 April 2013.

A Surveillance audit was due three months either side of 9 April 2012 but was postponed due to this unannounced inspection.

Service Description

Cressida Healthcare Limited provides Aged Residential Care Hospital (Geriatric) and Rest Home services. The occupancy and capacity is outlined below:

Area	Occupied	Capacity
Hospital	18	20
Rest Home	17	45
Total	**35**	**65**

Reasons for the inspection

The purpose of the inspection was to determine whether health care services being provided by Cressida Healthcare Limited 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; 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 this Act'.*

The inspection team

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

Methodology

The inspection was conducted to investigate the complaint made to the Ministry of Health 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
- individual staff interviews
- relative/ Resident interviews
- observation: During facility tours 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 residents' notes from the facility was examined.

Limitations

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

Entry meeting

Present: XXX XXX, Clinical Care Manager; XXX XXX, HealthCERT; and XXX XXX, HealthCERT.

A copy of the letter of introduction addressed to the Manager was provided to XXX XXX at 0845 hours. The administrator contacted the General Manager who spoke with XXX XXX and was informed about the unannounced inspection.

A proposed agenda for the day was discussed and 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.

Inspection findings

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

Consumer rights

1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	**Finding: Partially Attained** There are no resident/family meetings. Families are informed when there has been an accident, but have no input into care planning or mitigation of risks. Seven of seven residents' files could not evidence resident/family input into care plans. **CAR:** Ensure that full and frank information and open disclosure occurs from service providers. Ensure resident/family meetings are established.
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** Time frames of policy are not being met and there are no outcomes or improvements for staff learning. Family members stated their frustration around "no change" and "no one listening". Evidenced two complaints had not been acknowledged or addressed. Verbal complaints are not being acknowledged and processed. A family member stated they had used an official form to make a complaint, and that complaint had not been logged. A written complaint was evidenced on a staff notice board in the nurse's office. This complaint had not been lodged or acknowledged. **CAR:**

	Ensure complaints policy is followed and that complaint investigations are carried out and corrective actions commenced where required, and that staff are informed of outcomes.
1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	**Finding: Partially Attained** The complaints register had no entries regarding resident issues for this year (linked to criterion 1.1.13.1), however complaints were lodged. The three complaints on the register in March this year were all from staff for non-payment of allowances etc. **CAR:** Ensure that the complaints register is maintained and that actions are taken within set policy time frames.

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 needs clear definition as to responsibility and accountability for provision of service. This is causing friction between governance, managers and staff. This facility is about to have the third facility manager for 2012, and again will be without a permanent clinical manager from 27 June 2012 which could result in the escalation of clinical risk which is not being addressed. Authority, accountability and responsibility for the provision of service are not in place, with clinical managers having to seek approval from non-clinical general manager/owners. There is a lack of differentiation between governance and management which needs to be clearly defined in job descriptions. **CAR:** Ensure that the organisation is managed by a suitably qualified and experienced person with authority, accountability and responsibility for provision of services. 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 Clinical Care Manager had been endeavouring to fill both roles since the Manager left, without any training or documented responsibility or accountability. When this person leaves (imminent) a Registered Nurse (RN) will have to step up into her role without training or expertise. **CAR:** Ensure that in the absence of a manager, a suitably qualified and experienced person performs the manager's role.
1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.	**Finding: Partially Attained** Quality and risk at this facility is not being managed, understood or implemented by service providers. There are low attendances for staff meetings covering quality and risk. There are no corrective actions or improvements occurring from adverse events. There have been no quality meetings since February. **CAR:**

	Ensure that the quality and risk system is understood and implemented by service providers. Ensure that quality and risk meetings are established.
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: Partially Attained** There are no corrective actions or improvements occurring from adverse events. Complaints management, infection control, health and safety and restraint minimisation - all have policy in place but this is not being actioned or followed. **CAR:** Ensure that key components of service delivery are linked to an effective quality and safety system.
1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	**Finding: Partially Attained** There is poor orientation for new staff and attendance to staff training is poor, there are no strategies for staff who do not attend. Staff turnover is high both at caregiver and RN levels. New graduate RNs are not linked into the DHB Professional Development and Recognition Program for training and support. In addition caregivers are also undertaking full laundry services and meal preparation and kitchen duties with no training provided. **CAR:** Ensure the appointment (with clinical input) of appropriate service providers inclusive of kitchen and laundry staff to safely meet the needs of residents.
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 has been no staff education since March 2012 inclusive of compulsory training. When staff training was held only an average of 10 staff had attended from a total staff base of 40. There has been no evaluation of training for staff. **CAR:** Ensure that staff uptake of education, evaluation of education and staff orientation is managed in a manner that provides safe and effective services.
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** Health Care Assistant (HCA) hours are approximately 35.5 hours short for direct care for residents as per The New Zealand Handbook "Indicators for Safe Aged-care and Dementia-care for Consumers" (SNZ HB 8163:2005). Two of four RNs are in their first year of practice and they have no senior clinical oversight. There is no RN cover for rest home residents as evidenced in the lack of RN input into progress notes, and reassessment of care for rest home residents.

	New Zealand Standards Handbook, "*Indicators for Safe Aged-care and Dementia-care for Consumers*", (SNZ HB 8163:2005) notes there should be a minimum of 2 hours RN input per week for each rest home resident. The policy and rationale for staffing refers all changes to staffing levels to governance or general manager (non-clinical) including of usage of agency staff and does not take into account the guidelines (SNZ HB 8163:2005) or acuity of residents. There has been no specific time allocated for RNs to carry out the roles of Infection Prevention and Control or Restraint Management. **CAR:** Ensure that policy and rationale for staff levels is a clinical responsibility and that they clearly define provision for safe service delivery.
1.2.9.10 All records pertaining to individual consumer service delivery are integrated.	**Finding: Partially Attained** Residents attending their GP practice for three monthly reviews did not always have changes to treatment or documentation documented in their files. Accident and incident forms were not filed in residents' notes Wound assessments were not evidenced in resident's notes There were no clinical notes written by RNs (clinical input/oversight)for rest home residents **CAR:** Ensure consumer notes 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: Partially Attained** Although initial assessments are carried out for residents these are not being consistently reviewed and updated. Resident/family input is not evident in the development of care plans. **CAR:** Ensure that care plans are developed with the consumer, and where appropriate their family/whānau of choice or other representatives as appropriate.
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 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 two residents noted at the inspection that required reassessment due to changing physical needs within the facility, there has been no on-going referral to NASC or dietician, or wound care nurse specialists for residents at this facility. **CAR:** Ensure care plans are documented to serve as the basis for service delivery planning and are current.

1.3.6.2 Appropriate links are developed and maintained with other services and organisations working with consumers and their families.	**Finding: Partially Attained** Links to other services for example dietician, podiatrist or wound care specialist, when there had been a perceived need, was not evidenced. There is a potential for clinical staff to be unaware to changes made to resident needs and changed medications/ treatment following residents being taken to GPs by family members for three monthly checks or when needing to be seen. It was evidenced that there was no RN input in rest home resident notes. **CAR:** Ensure that other services and organisations work with consumers and their families when there is a perceived need. Ensure that appropriate documentation and communication occurs when there has been either GP or hospital consultations 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** There has been no activities person in place at the facility for two months Noted: a new qualified activities person had just commenced work **CAR:** Ensure that activities are planned and provided for residents
1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	**Finding: Partially Attained** Evaluations are not being completed and subsequently care plans not updated. Three of six care plans reviewed were not current and had not been evaluated. **CAR:** Ensure that care plans are changed and updated where progress is different from expected. Ensure that evaluations of care are carried out and care plans updated.
1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	**Finding: Partially Attained** RN competency for medication not carried out, and care givers checking controlled medication are not competent. Adverse event - medication error 23/6/12 tablets left in sachet in room, taken by the resident at the wrong time. **CAR:** Ensure all RNs and HCAs are competent to administer medications
1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	**Finding: Partially Attained** The menu plan is not followed, food is being prepared hours ahead of time and no monitoring of food temperatures is carried out. The budget of this facility for food is set too low to allow for the menu to be followed. The kitchen was using the summer menu as they did not have a winter menu or the recipes to follow. There was insufficient crockery for resident usage for each meal, for the low number of residents currently in the facility. The kitchen cleanliness was poor; high cleaning had not been carried out. HCAs had a list of duties related to the kitchen that were to be completed on night duty – these were not being done, as staff had insufficient time to attend to them after caring for residents. The cook's hours (six hours per day) were solo with no kitchen hand, to assist.

	During the day HCAs were responsible for preparation of breakfast, serving breakfast and cleaning up and dishes, lunch required HCAs to serve and clean up and do dishes, dinner meal required HCAs to heat the meal that had been prepared, and HCA staff had not been trained for meal preparation. After dinner the HCAs were again responsible for the cleaning up of the dining room and dishes. Minimal vegetables were sighted in the cool store, the weekly delivery had been the day before and all that remained for the week was a lettuce and cabbage. Fresh fruit supply was meagre. The kitchen was inspected at approximately 1400 hours and there were dirty dishes on the benches from lunch and clean dishes had not been put away. The tea trolley was partially set for afternoon tea. The dishwasher was old and it was reported that it breaks down often. **CAR:** Ensure that all nutritional need of residents is in line with guidelines appropriate for residential aged care. Ensure staff are trained in Food Safety and that sufficient staff are employed to manage food services Ensure that the food budget allows for both dietician and clinical input to ensure adequate funding.

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** Seven locations around the facility had areas of wet carpet, especially leaking around doors and windows. Bedrooms where the wet carpet was found did not have residents although hallways with wet patches had residents and staff walking through the areas. There were three areas of high risk where a builder had begun refurbishing - in one room a toilet had been removed and half the floorboards at the entrance to the toilet removed – with a paper sign on the door – Do Not Enter, but no lock to prevent residents in that area opening the door and entering. In two bedrooms a builder had begun major work following his assessment of the leaks, which entailed removing wall and ceiling cladding in the rooms as well as some areas of the hall. Staff at the facility were unaware of the work being undertaken and there were no health and safety or infection prevention and control assessment, or planned development with the builder, and clinical staff. A ladder had been left outside in a resident's area giving access to the roof of the building. Residents were still residing in these areas of the home and were moving around the builder. Numerous empty bedrooms held equipment stored untidily, and they were not locked to prevent residents wandering in. The facility has capacity for up to 65 residents – there were only 35 residents at the facility on the day of the inspection. The placement of the residents was spread throughout the facility with some residents at quite a distance from the nurse's station and placed in rooms at the end of wings with staff having to walk past numerous empty rooms to reach them.

	CAR: Ensure that maintenance is planned and carried out with consideration of consumer and service provider safety, needs, and abilities. Ensure safe placement of residents is initiated away from areas under construction and areas of isolation.
1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	**Finding: Partially Attained** During the tour it was observed that one area in particular in a corridor near a ramp there were found to be marked cracks in the walls and ceiling with considerable wet patches around the area (ceiling, walls and floor). The ceiling appeared to be bowed and the floor uneven. No equipment was available to staff within the facility to dry the carpet, in this area and no signs warning of the flooding and changing conditions were in place. **CAR:** Ensure that this area is immediately risk minimised for residents and staff, and that an independent building inspection is carried out regarding structural safety.
1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.	**Finding:** External areas for residents were untidy, the garden had been cleared however pine needles and leaves were all over the ramps and concreted areas, and these were very slippery underfoot. **CAR:** Ensure that consumers are provided with safe and accessible external areas that meet their needs
1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.	**Finding: Partially Attained** It was observed that there were no face shields for staff use in sluice rooms; linen was stored on the floor in linen cupboards. The laundry work was fitted into spare time by HCAs and often the soiled laundry backs up for 24 hours and causes the smell to permeate that area of the facility. Care staff are responsible for all linen while the laundry staff look after personal clothing only. The laundry room contained approximately six bags of dirty laundry and the laundry was mixed containing linen and personal clothing. There were specific bags for each type of laundry provided, but not used. There was no oversight by the clinical infection prevention and control coordinator or staff training, There had been no monitoring of laundry processes for effectiveness. **CAR:** Ensure that processes are monitored and evaluated inclusive of infection, prevention and control to ensure effectiveness.
1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	**Finding: Partially Attained** There were insufficient food and water supplies stored at the facility for an emergency. **CAR:** Ensure that the facility has sufficient supplies to meet the Ministry of Civil Defence and Emergency Management guidelines.

1.4.7.5 An appropriate 'call system' is available to summon assistance when required.	**Finding: Fully Attained** Bells have been an issue – although now repaired after DHB letter. Pager system with staff.

Infection prevention and control

Standard/Criteria	
3.1.8 There is a clear process for early consultation and feedback with the infection control person/team, when significant changes are proposed to staffing, practices, products, equipment, the facility, or the development of new services.	**Finding: Partially Attained** The general state of the laundry and 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. The building construction underway is a potential IPC risk with no clinical input. **CAR:** Ensure that there is a clear process for early consultation and feedback with the infection control person/team, when significant changes are proposed to staffing, practices, products, equipment, the facility, or the development of new services.

Summation meeting

A summation meeting was attended by: XXX XXX, Clinical Care Manager; XXX XXX, Portfolio Manager, Taranaki DHB; the DHB's Associate Director of Nursing; XXX XXX, HealthCERT; and XXX XXX, HealthCERT.

The Advisors 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 Advisors confirmed that there would be findings against the Health and Disability Services Standards as per the above table.

Cressida Healthcare Limited is required to take the above corrective actions to improve compliance against the Health and Disability Services Standards. Ongoing monitoring will be undertaken by Taranaki DHB and the Ministry of Health.

Conclusion

The unannounced inspection occurred because of complaints received. The focus of the inspection was on whether the provider was meeting the Health and Disability Services Standards specific to the allegations in the complaints. The inspection found that the complaints were substantiated.

The following findings were identified at the inspection.

Resident Rights:

- there were no resident/family meetings or family involvement in the care planning process
- there was no response sent out to complainants, no investigations had occurred and no corrective actions or learning for staff following complaints was evident
- the complaints register was not up-to-date, actions were not being taken and complaints were not being managed within the policy time frames.

Organisational Management:

- authority, accountability and responsibility for the provision of service were not in place
- clinical managers had to seek approval from a non-clinical general manager or owners
- there was a lack of differentiation between governance and management - this needs to be clearly defined in job descriptions
- there was no clinical input at governance level into decision making, which affects all levels of the provider's services
- the facility and clinical manager need clear definition as to the responsibilities and accountabilities of their roles.
- the manager role at this facility has not always been held by a suitably qualified and/or experienced person
- quality and risk at this facility was not being managed, understood or implemented by service providers.
- there was insufficient appointment of appropriate service providers to safely meet the needs of consumers
- there was poor staff uptake of education, evaluation of education and staff orientation
- records pertaining to individual consumer service delivery were not integrated
- progress notes were not written in an accurate and timely manner.

Continuum of Service Delivery:

- the lack of updating of assessments resulted in care plans that were not current
- resident/family involvement in the development of care plans was not evident
- care plans were only reviewed at the required six-monthly interval and did not reflect changes in acuity or events requiring short-term care plans or alteration in care
- activity plan goals were not met, reassessments of activity goals was not carried out
- appropriate links were not developed and maintained with other services
- the medicines management system was not always implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation
- the menu plan was not followed, health care assistants had to carry out the meal services and kitchen duties, they had no training for this role and there were issues regarding food being prepared hours ahead of time and no monitoring of food temperatures for meals
- the kitchen was using the summer menu as there was a winter menu or other recipes to follow

- there was insufficient crockery for resident usage for each meal, for the low number of residents in the facility
- some items to meet the menu were not ordered, as a set budget had to be complied with
- kitchen cleanliness was poor; high cleaning had not been carried out.

Safe and Appropriate Environment:
- maintenance was not planned or carried out with consideration of consumer and service provider safety, needs, and abilities
- the safe placement of residents had not been initiated away from areas under construction and areas of isolation.
- consumers were not provided with safe and accessible external areas that met their needs
- laundry duties were carried out by health care assistants and there was no oversight by the clinical infection prevention and control coordinator or staff training.
- there had been no monitoring of laundry processes for effectiveness
- there was an insufficient food and water supply stored at the facility for an emergency.

Infection Prevention and Control:
- there were reports to the general manager and governance, however, there was no clinical role at that level of the organisation
- although statistics on infections were monitored, there was no evidence of corrective actions or improvements occurring from this process
- there was no risk minimisation for cross infection of staff working across the different roles of caring, kitchen and meal preparation and laundry, or maintenance.

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: 1.1.9.1, 1.1.13.1, 1.1.13.3, 1.2.1.3, 1.2.2.1, 1.2.3.1, 1.2.3.5, 1.2.7.3, 1.2.7.5, 1.2.8.1, 1.2.9.10, 1.3.3.2, 1.3.5.2, 1.3.6.2, 1.3.7.1, 1.3.8.3, 1.3.12.3, 1.3.13.1, 1.4.2.3, 1.4.2.4, 1.4.2.6, 1.4.6.2, 1.4.7.1, 1.4.7.5, 3.1.8 as identified in the Inspection Report must be submitted to the Taranaki District Health Board by 30 August 2012.

2. HealthCERT may elect to carry out an unannounced 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
- Rosters (last month and this month)
- Abuse and Neglect Policy
- Complaints management policy
- Complaints records for the last six months
- Clinical Assessment Tools in current use
- Staff training records and in-service training programme
- List of staff with current first aid certification
- List of staff with current medication competency
- Quality and risk management plan
- Emergency Response Policy
- Incident and accidents records for the last six months
- Minutes of staff meetings
- Minutes of quality meetings
- Resident files