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# Final Inspection Report

# Elmwood House

# Date of inspection: 6 August 2013

HealthCERT
Provider Regulation
Clinical Leadership, Protection and Regulation

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## Provider Details

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| Provider: | Elmwood House Partnership |
| Premises: | Elmwood House, Napier South, Napier |
| Contact Person: | Geoff Yates |
| Internal File Ref: | GO6811-C01 |
| Inspection Date: | 6 August 2013 |

## Executive Summary

The Ministry of Health (the Ministry) received a complaint on 5 August 2013 from the daughter of Mr A, a resident at Elmwood House. The complainant alleged that, when visiting her father, she observed residents who were tied to dining room chairs and one resident was trying to free another resident using a knife. The complainant was also concerned that her father had sustained unexplained bruising and a recent head injury that had not been seen by a GP in a timely manner.

The complaint raised concern that Elmwood House Partnership could have been in breach of its obligations as a provider certified under the Health and Disability Services (Safety) Act 2001 (the Act) to provide health care services at Elmwood House.

In summary, the complainant alleged that:

- her father had unexplained bruising
- her father sustained an unexplained head injury and was not seen by a GP in a timely manner
- residents were left in the lounge unsupervised and some residents were tied to chairs
- a resident was asked by another resident to get a knife and release her restraint
- the medication trolley was often left unattended.

As a result of this complaint, an unannounced inspection of Elmwood House was undertaken by the Ministry on 6 August 2013 in accordance with sections 40, 41 and 43 of the Act.

On the basis of evidence reviewed, the Ministry concluded that Elmwood Partnership had failed to fully comply with relevant Health and Disability Services Standards (NZS 8134:2008). The partially attained standards related to complaints management, quality and risk management, adverse event reporting, assessment, planning, restraint minimisation, good practice, service delivery/interventions, and infection prevention and control. All but two aspects of the complaint were substantiated, and Elmwood House Partnership is required to undertake the corrective actions outlined in section six. On-going monitoring will be undertaken by the Ministry in conjunction with Hawke's Bay District Health Board.

## Background

*Law*

Providers of health care services must be certified by the Director-General of Health (sections 9(a) and 26 of the Act), and must comply with all relevant health and disability service standards (section 9(b)).

The relevant service standards are approved under the Health and Disability Services (Safety) Notice 2008, and the standard approved is the Health and Disability Services Standards NZS 8134:2008.

*Facts*

***a) The complainant was concerned that her father had unexplained bruising including some facial bruising.***

On the day of the inspection, there was no evidence of bruising on Mr A's face. Care plans and progress notes did not mention any bruising having occurred. Mr A's medical notes did not mention bruising. However, there was a wound dressing on the crown of his head.

***b) The complainant alleged her father had sustained an unexplained head injury.***

The clinical manager advised that Mr A had suffered an un-witnessed fall on 30 July 2013. He was found on the floor by a care giver. The manager examined Mr A who had sustained a large haematoma to the crown of his head. The wound was dressed and Mr A had his blood pressure and pulse recorded.

There was no evidence of updates to Mr A's long-term care plan after the incident, or a short term care plan. There was no entry in the clinical notes by a registered nurse (RN) following the fall. There were no specific instructions or guidelines for care givers to observe following Mr A's head injury. The incident and accident report showed that Mr A's daughter had been notified of the fall.

Mr A became unwell the next day, complaining of shortness of breath, swelling ankles and feet, and pain in his right shoulder and right hip. A RN recorded his blood pressure and pulse. Mr A's daughter was notified of this episode. However, the GP was not contacted to review Mr A. There was no evidence of a pain assessment despite Mr A complaining of pain.

The locum GP was called on 1 August 2013, two days after Mr A's fall. The locum GP noted that Mr A fell two days prior, "no evidence of any external bruising, complaining of shortness of breath and oedema to feet and ankles". The GP also noted that Mr A was complaining of pain in his right shoulder and right hip and ordered an x-ray for the following day. Mr A was also prescribed a diuretic to assist in relieving any fluid retention.

There was no evidence of Mr A's care plan and progress notes being updated following the GP's visit. There was no evaluation report of the effect of the diuretic or as to whether the shortness of breath and ankle oedema had resolved. No further pain assessment was recorded.

On 2 August 2013 Mr A was taken to the public hospital for x-rays of hip and shoulder. Mr A returned to Elmwood House late that night, instructions from the hospital were provided in a discharge letter. Instructions were given regarding mobilisation following a right facia block with lignocaine and Mr A's right arm was to be kept in a sling. There was no evidence that the night RN had read the instructions or checked Mr A upon his return. The hospital instructions were not transferred into the care plan or the progress notes after Mr A returned. The handover sheet the following day did not refer to Mr A.

During the investigation, the advisors noted that Mr A had been placed on an anti-roll mattress to assist with preventing him from falling from the low bed. However, there was no documentation regarding the assessment for this type of mattress, or rationale or guidelines and instructions for the care givers. No evaluation of using this type of mattress was documented.

***c) The complainant observed residents left unsupervised in the main dining room and residents were tied to a chair.***

It could not be established if all staff in the dementia unit were taking a break at the same time and not observing residents.

The clinical nurse manager advised that there were residents who are restrained with pelvic restraint. She acknowledged that there was one resident who at times would call out incessantly to be freed from the restraint. The nurse manager also acknowledged that there was a resident who tried to help other residents with their requests.

Staff acknowledged that it was possible for residents to access the kitchen if the door was left unlocked or if a resident was physically able to reach around the service hatch to open the door.

The advisors witnessed two residents who were physically restrained with pelvic restraints, and observed a resident who talked incessantly. The care giver and nurse manager confirmed that they had heard this particular resident ask respectively for assistance to be freed from the restraint.

***d) The complainant witnessed the resident who was tied to a chair ask another resident to retrieve a knife from the kitchen, to untie her.***

The nurse manager confirmed that it was possible that this could have occurred although such an incident was not witnessed by staff. The complainant alleged that she had to call the staff from the lunch room twice to attend to the situation.

There was no evidence of any incident form filled in following the concern raised by the complainant.

When reviewing the files of the residents who were restrained there was no evidence of each episode of restraint being documented in sufficient detail to provide an accurate account of the need for use of restraint.

The Ministry concluded that all but two aspects of the complaint were substantiated.

I. There was no evidence of the medication trolley being left unattended.

II. There was no evidence from medical notes of any external bruising to Mr A's face or other areas.

*Certification*

Elmwood House Partnership is certified for three years with the certificate expiring in November 2014.

## Inspection Team

The inspection was undertaken by XXX XXX and XXX XXX , Senior Advisors 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 part owner/director
- Interview with two part time clinical nurse managers
- Interview with assistant manager (care giver) dementia unit (non-clinical)
- Interview with RNs
- Interview with cook
- Physical inspection of premises / 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 the complainant 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.

| evant ndard/Criterion | Findings | Required Corrective Action/s | Rating and time frame. |
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| **ndard 1.1.13** | Not all complaints were logged into | **Corrective Action Request:** | **Rated:** Moderate |

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| erion 1.1.13.3 | the complaints register. There was no documentation in the complaints register that demonstrated that complaints had been responded to within the specified timeframe according to policy. During the inspection the owner/director confirmed he had taken all complaints correspondence off site to another office. | Ensure the complaints register is sufficiently detailed and includes all actions undertaken with evidence of correspondence to complainant acknowledging complaint and any further correspondence. | **Time Frame:** One month |
| **ndard 1.2.1** erion 1.2.1.1 | There was a lack of differentiation between governance and management which needed to be clearly defined in job descriptions. | **Corrective Action Request:** Ensure the roles of governance and management are clearly defined. | **Rated:** Moderate **Time Frame:** Three months |
| **ndard 1.2.3** erion 1.2.3.8 | Corrective action plans were not consistently developed where these were required. For example: in the five of five files reviewed, residents care plans did not consistently include details of all applicable interventions required to minimise risk. | **Corrective Action Request:** Ensure corrective actions plans are consistently developed where required, implemented and monitored for effectiveness. | **Rated:** Moderate **Time Frame:** Two months |
| erion 1.2.3.6 | There was minimal documented evidence available to show that quality indicators were being analysed and evaluated to identify trends and opportunities for improvement. There was no reporting of clinical indicators to the governing body and to staff.<br>There was no benchmarking with other providers. | Ensure short term care plans are sufficiently detailed and provided guidance for staff on relevant prevention strategies following reported incidents<br>a) Provide documented evidence that clinical indicators are being collated, analysed and evaluated to identify trends, and that the results of this analysis is being reported to the governing body and staff on a regular basis.<br>b) Discuss options for benchmarking against other providers. | **Rated:** Moderate **Time Frame:** Three months |
| **ndard 1.2.4** erion 1.2.4.3 | The incident and accident forms had been collated monthly for the manager's report. However there was no evaluation or trend analysis. On the day of the inspection there were no reports available for June or July 2013. | **Corrective Action Request** Ensure all monthly data is collated and reviewed for evaluation and trending. | **Rated:** Moderate **Time Frame:** Two months |
| **ndard 1.2.8** erion 1.2.8.1 | The organisation did not have a verifiable process to identify how staffing needs were identified and changed to ensure the care needs of residents are being met. | **Corrective Action Request** Ensure a process is implemented to demonstrate that staffing needs are identified and changed as the result of changes in clients' care needs and or levels of care. | **Rated:** Moderate **Time Frame:** Two months |
| **ndard 1.3.2** erion 1.3.3.2 | In four of the five files reviewed there was no evidence of family/whanau input. | **Corrective Action Request** Ensure family/whanau are involved in service provision planning. | **Rated** Moderate **Time Frame** Three months |
| **ndard 1.3.4** erion 1.3.4.2 | One resident had advanced dementia had frequent aggressive episodes displaying disturbing behaviour and may not have been appropriately placed. An urgent request was made to address this concern. | **Corrective Action Request:** Provide evidence that this consumer is reassessed by the NASC team to ensure that this consumer is appropriately placed. | **Rated:** High **Time Frame:** One month |

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| | There were three incident and accident reports that described this resident assaulting other residents. | | |
| **ndard 1.3.5**<br>eria 1.3.5.2 | The five files reviewed in the dementia unit did not clearly identify strategies for minimising episodes of challenging behaviours based on assessment and prevention. | **Corrective Action Request:**<br>Ensure the care plan describes the required supports and interventions to achieve the desired outcomes identified by the on-going assessment process. | **Rated** Moderate<br>**Time Frame**<br>Three months |
| **ndard 2.1.1**<br>eria 2.1.1.4 | Enablers were not used on a voluntary basis and did not constitute the least restrictive option. | **Corrective Action Request**<br>Ensure the correct understanding and usage of enablers vs. restraint. | **Rated** Low<br>**Time Frame**<br>Three months |
| **ndard 2.2.1**<br>erion 2.2.1.1 | The facility was not able to demonstrate a process for determining approval of all types of restraint. The policy did not clearly define this process. Staff were not able to identify who the restraint coordinator was. | **Corrective Action Request**<br>Ensure there is a clearly defined process for determining restraint in the restraint policy, and the restraint coordinator is clearly identified. | **Rated** Moderate<br>**Time Frame**<br>Three months |
| **ndard 2.2.3**<br>erion 2.2.3.4 | Each episode of restraint was not documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, outcome, as considered in the criteria list a-g. | **Corrective Action Request:**<br>Ensure that monitoring and documentation occurs during each episode of restraint. | **Rated low**<br>**Time Frame**<br>One month |
| **ndard 2.2.4.**<br>erion 2.2.4.1 | Evaluations of each episode of restraint were not occurring in order to determine if criteria (a) to (k) is being met. | **Corrective Action Request:**<br>Ensure evaluations are occurring as required and documented. | **Rated Low**<br>**Time Frame**<br>Three months |
| **ndard 2.2.5**<br>eria 2.2.5.1 | There is no comprehensive review of restraint practices in order to determine (a) to (h) are met. | **Corrective Action Request:**<br>Ensure there is a review of the restraint practices and this is well documented. | **Rated Low**<br>**Time Frame**<br>Three months |

## Meeting at end of inspection

Present: XXX XXX and XXX XXX, Senior Advisors, HealthCERT, Ministry of Health; XXX XXX, Hawke's Bay DHB Portfolio Manager; Geoff Yates, part owner/director of Elmwood House Partnership; XXX XXX and XXX XXX joint clinical managers, assistant manager.

XXX XXX thanked the management team and staff 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:

- all but two issues raised by the complainant appeared to be substantiated but further analysis was required to confirm this
- not all complaints were registered in the complaints register and management of complaint documentation required improvement
- care plans were generic and not individualized for each resident.
- there was a breakdown in both written and verbal communication from one shift to another
- clinical leadership was not evident.

## 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. Elmwood House Partnership is required to undertake the following corrective actions within the specified timeframes. If the corrective actions are not achieved, the Ministry may take action in relation to non-compliance with the requirements of the Act.

The new conditions on the certification schedule include the findings from the spot audit on 30 May 2013.

**Required corrective actions**

A written progress report that outlines all actions undertaken by the provider in relation to corrective measures against Health and Disability Services Standards 1.3.4.2, 2.2.3.4 (as approved under section 13 of the Act) must be submitted to your District Health Board by 15 September 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.

A written progress report that outlines all actions undertaken by the provider in relation to corrective measures against Health and Disability Services Standards 1.1.10.7, 2.1.1.4 (as approved under section 13 of the Act) must be submitted to your District Health Board by 15 October 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.

A written progress report that outlines all actions undertaken by the provider in relation to corrective measures against Health and Disability Services Standards 1.2.1.1, 1.2.4.3, 1.2.8.1 (as approved under section 13 of the Act) must be submitted to your District Health Board by 15 November 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.

A written progress report that outlines all actions undertaken by the provider in relation to corrective measures against Health and Disability Services Standards 1.3.3.2, 1.3.5.2, 2.1.1.4, 2.2.1.1, 2.2.4.1, 2.2.5.1 (as approved under section 13 of the Act) must be submitted to your District Health Board by 15 December 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.

A written progress report that outlines all actions undertaken by the provider in relation to corrective measures against Health and Disability Services Standards 1.2.3.1, 1.3.3.4, 1.3.6.1 (as approved under section 13 of the Act) must be submitted to your District Health Board by 15 January 2014. 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.

If the corrective actions are not achieved, the Ministry may take action in relation to non-compliance with the requirements of the Act.

Elmwood House Partnership was given a copy of the draft report and asked to comment on any factual errors. Mr Geoff Yates responded in a letter dated 4 September 2013. The Ministry considered Mr Yates' comments before finalising this report.