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Inspection Report

Cressida Eversleigh Limited

Date of Inspection: 20 June 2012

Contents

Executive summary

HealthCERT received information from Waitemata District Health Board (DHB) on 12 June 2012 regarding a complaint about the standard of care provided by Cressida Eversleigh Limited to residents at Eversleigh Hospital in Belmont, North Shore City.

The complainant's allegations related to: consumer rights; governance and management structure; high turnover of manager position; low staff levels and staff training; quality and risk management including the internal audit process; care planning including weight loss management, nutrition, end of life care, medication management and pain management; complaints management; open disclosure; communication; and response to emergency situations. The DHB asked HealthCERT to investigate the allegations.

A further complaint outlining similar concerns was forwarded by the DHB on 19 June 2012. HealthCERT undertook an unannounced inspection at Eversleigh Hospital on 20 June 2012 to determine whether health care services provided by Cressida Eversleigh Limited 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 29 partially attained criteria against the relevant standards. These findings were in the areas of: Informed consent; 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 equipment; restraint management; and infection prevention and control.

The complainants' allegations were substantiated. Cressida Eversleigh Limited must complete the required improvements to ensure compliance against the Health and Disability Services Standards. Ongoing monitoring will be undertaken by Waitemata DHB in conjunction with the Ministry of Health.

Recent history

The provider had a provisional audit prior to purchase in September 2010. At this audit there were 38 partial attainments against the standards which required improvements. The provider was issued with a one year certification with a surveillance audit required at the mid-point of this period.

The surveillance audit undertaken in May 2011 resulted in 42 partially attained criteria and four unattained standards. At this point, Waitemata DHB followed up, with a Clinical Nurse Specialist working with the provider to ensure improvement.

In July 2011 the DHB received a complaint concerning poor care, lack of staff, weight loss and nutrition management, and medication management at Eversleigh Hospital. This complaint was substantiated and the provider was required to carry out improvements.

The certification audit in September 2011 resulted in 27 partially attained criteria against the standards. The DHB continued to work with the provider.

There have been four facility managers since the purchase of the facility by Cressida Eversleigh Limited.

On 12 June 2012 the Ministry of Health received a complaint via Waitemata DHB which alleged Cressida Eversleigh Limited could have been in breach of its obligations as a certified provider under the Act to provide services at Eversleigh Hospital. The complainant's allegations related to:

- consumer rights
- governance and management structure
- high turnover of manager position
- low staff levels and , inadequate staff training, quality and risk management, including internal audit process
- care planning, management of weight loss, nutrition, end of life care, medication and pain management
- complaints management, open disclosure, communication
- response to emergency situations.

A further complaint of a similar nature was forwarded by the DHB on 19 June 2012.

Service description

Cressida Eversleigh Limited provides Aged Residential Care, Hospital (Geriatric/ Medical), and Rest Home services (excluding Dementia). The occupancy and capacity is outlined below:

Area	Occupied	Capacity
Hospital	26	29
Rest Home	4	7
(Swing beds)		(5)
Total	**30**	**36**

Reasons for the inspection

The purpose of the inspection was to determine whether health care services being provided by Cressida Eversleigh Limited were being provided in compliance with section 9 of the Act. 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, Senior Advisor, HealthCERT, and XXX XXX, Senior Advisor HealthCERT, under the delegated authority of the Director-General of Health.

Methodology

The inspection was conducted to investigate the complaints referred 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 Temporary Clinical Manager
- interview with Registered Nurse
- individual staff interviews
- relative/resident 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 residents' notes from the facility was examined.

Limitations

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

Entry Meeting

Present: XXX XXX, Temporary Clinical Manager; XXX XXX, Service Manager; XXX XXX, Senior Advisor, HealthCERT; and XXX XXX, Senior Advisor, HealthCERT.

The introduction meeting covered the following points:

A copy of the letter of introduction addressed to XXX XXX, Manager, was provided to XXX XXX at 9.15 am.

A proposed agenda for the day was discussed including 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 Standards were identified on the day of the inspection.

Consumer rights

Standard/Criteria	

1.1.3.7 Consumers are kept safe and are not subjected to, or at risk of abuse and/or neglect.	**Finding: Partially Attained** Only a small number of staff have attended training sessions on abuse and neglect. The facility is staffed by new graduate Registered Nurses (RNs), with no senior clinical oversight and risk management in place regarding abuse and neglect. There have been confirmed issues of abuse and bullying in respect of two staff members who have now resigned, related to the complaint. However there has been no support and education for staff. (Linked to 1.1.13.1) **CAR:** Ensure all staff are trained in abuse and neglect prevention and that staff have senior clinical management oversight.
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. Family is informed when there has been an accident, but has no input into care planning or mitigation of risks. A resident's daughter with Enduring Power of Attorney (EPOA) asked the RN for the current medical information, blood test results and the GP's decision. The RN was unable to answer. The blood tests had been taken at the last GP's visit. Required changes to medication were needed, however the RN had not followed up or ensured decisions or changes were made. The daughter also asked whether her mother's condition had changed and was given no explanation, other than the RN would make enquiries. Interviews with families revealed that they had to ask for information rather than staff being forthcoming. With regard to the complaint for resident (B), the family communication sheet had no record of resident's five falls and there was no record of the family being notified. (Linked to 1.2.4.3). **CAR:** Ensure that full and frank information and open disclosure occurs from service providers.
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** Documentation of advanced directives and resuscitation is not clearly defined and the forms are confusing. One resident with dementia had the consent signed by her husband (not the EPOA) and the advanced directive was signed by the resident and not witnessed. Another resident with dementia had the GP signing to say she was competent, however the EPOA had signed the advanced directive and resuscitation form. **CAR:** Ensure that all consent, advanced directive and resuscitation documentation is clear and is compliant with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).
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** The initial response is sent out to complainants, however there no evidence of an investigation and/or corrective actions developed or learning for staff following the complaints. Families see no changes occurring after making a complaint. The number of complaints received has been high for a small facility over the last few months. It was noted that the short term locum manager was starting to address this. **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 is not up to date, actions are not being taken and complaints are not being managed within the policy time frames. **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** There has been no permanent clinical manager at the facility for seven months. Various staff has been in acting roles including non-clinical staff. Authority, accountability and responsibility for the provision of services are not in place. Clinical managers have 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. At the governance level there is no clinical input into decision making apart from a 12 week period early in 2012. The governance of the facility and clinical management needs to be clearly defined as to the responsibility and accountability for the provision of service (this has caused friction between the owners, managers and staff). Seven months without a permanent clinical manager has resulted in an escalation of clinical risk. **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 manager role at this facility has not always been held by a suitably qualified and/or experienced person resulting in poor outcomes for residents. In areas such as purchasing, maintenance, complaint management, staffing levels and skill mixes decisions are being made by non-clinical staff. **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. A new quality system is being developed, however the events reporting and complaints management issues are not being resolved. **CAR:** Ensure that the quality and risk system is understood and implemented by service providers.
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;	**Finding: Partially Attained** Although data has been compiled by the service manager, there have been no corrective actions developed or improvements to implement change and provide better outcomes for residents or staff. There has been no clinical follow up regarding events or complaints. Infection control, health and safety and restraint minimisation systems have not been effectually managed. Staff were unaware of responsibilities for these areas and no specific training had been given to new graduate RNs appointed to these roles, (linked 1.2.7.5).

(b) Complaints management; (c) Infection control; (d) Health and safety; (e) Restraint minimisation.	**CAR:** Ensure that key components of service delivery are linked to an effective quality and safety 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** Although events have been documented by staff, there has been no identification of opportunities to improve service and minimise risk. There has been no clinical follow up to put in place corrective actions or inform staff. There are no corrective actions or improvements occurring from adverse events. **CAR:** Ensure that events are followed up and that actions are taken to improve service and minimise risk.
1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	**Finding: Partially Attained** Health Care Assistant (HCA) hours are approximately 70 hours under guidelines, (SNZ HB 8163:2005). In addition HCAs are also undertaking full laundry services and meal preparation for breakfast. Meal times are difficult as staff are called away to answer bells and there are not enough staff to feed and assist the residents with their meal. Those residents who can feed themselves are left unattended while eating. Observation at lunch time reveals one HCA was attempting to feed seven residents. The meals were not warm, there were no stools for staff to sit comfortably to feed residents, only the arms of another resident's chair. Bells were ringing throughout lunch meal. (Linked to 1.3.13.5). From 1300 hours to 1500 hours there are only two HCAs on the floor and they have to provide afternoon tea as well as answer bells. Again from 2100 hours to 2300 hours there is only one HCA and one RN in the facility. At weekends there are new part time staff on duty, no senior HCAs, they have just been given one or two orientation days with another HCA. As they only work two days per week they often work double shifts to fill the gaps in the roster. (Linked to 1.2.7.5). It is noted that one RN is working 60 hours per week. The majority of RNs are in their first year of practice and they have no clinical oversight or on-going education and training. All RNs work 12 hour shifts. **CAR:** Ensure clinical input occurs at the appointment of appropriate staff 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** Training plan for 2012 provided – evidence of monthly training sessions on policy are being held. The issue is attendance (range from 5-11 attendees per session), evaluations of sessions are inconsistent, and there is no documentation available for staff not attending to get the information. Although it was noted that there had been frequent skin tear incidents through mobilisation of residents, there were only five attendees at this session in May. There is only care giver to care giver manual handling and hoist training during orientation of new staff.

	The cleaner has had no training regarding chemical usage or storage in respect of health and safety. (Linked to 1.4.6.3). There is poor orientation for new staff and attendance to staff training is inconsistent, there are no strategies for staff who do not attend. Staff turnover is high both at HCA and RN levels. **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** This facility has been without a senior clinical manager, relying on new graduate RNs on duty in the hospital and the service manager (non-clinical). There is no link for new graduates to a professional development recognition program with the DHB or senior clinical supervision and oversight. 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. (Linked to 1.2.3.1). **CAR:** Ensure that policy and rationale for staff levels has a clinical perspective and that they clearly define provision for safe service delivery.
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** Progress notes are written once per day and are often written by the RN on night duty .The reports in progress notes do not describe the residents actual condition e.g. change in acuity, changes to care, monitoring etc. This facility has hospital level services where acuity and residents conditions can and do change frequently and staff needs to be informed of these changes. With regard to the complaint resident (A), progress notes were written by RNs and recorded basic care that was provided. There was difficulty in assessing when the issues raised in the complaint had occurred in respect of the progress notes. **CAR:** Ensure that progress notes are written in an accurate and timely manner for both hospital and rest home setting.

Continuum of service delivery

Standard/Criteria	
1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.	**Finding: Partially Attained** Although initial assessments are carried out for residents, these are not being consistently reviewed and updated. This lack of re-assessment does not allow for care plans to be current. **CAR:** Ensure that assessments are carried out as acuity changes and at least six monthly.

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** Resident/family involvement was 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 intervals, and they are not changed when the resident condition changes and short term care plans or changes in the care plan are not evident. A resident's daughter was observed asking the RN why her mother was sleepy and very "blue" today, the RN was unsure, and had to be asked why the oxygen concentrator next to the resident was not in use. RN unable to explain the link between the resident's need for continuous oxygen therapy to the daughter. All staff needs to ensure that oxygen therapy is in place when the resident sat out of bed. A respite resident's care plan had not been completed since admission five days previously. The resident had a high risk for falls and no short term care plan developed. The resident had not been seen by her GP since admission, as her own GP was not available to visit the facility. **CAR:** Ensure care plans are documented to serve as the basis for service delivery planning and are current.
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** It was evidenced that activity plan goals are not met, reassessments of activity goals are not carried out, and the facility has one activity staff member with 20 hours per week. **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** With regard to the complaint concerning a deceased resident (B), the week prior to her death the GP increased her analgesia. It was noted that she had increased weakness, and increased pain in her legs, a liniment was used to give local relief. There was a slow deterioration over 24 hours and the cares recorded appeared to respond to the ongoing deterioration of the resident. No untoward events were reported in the progress notes. (Linked to 1.1.9.1). With regard to the complaint concerning resident (A), the file was examined looking at medication, GP notes and progress notes during the end stage of life. It was evident that morphine was administered erratically prior to death. Some shifts up to four doses were given, other shifts a lot less, and in some other shifts none. Notes described a family request for use of a drug to reduce anxiety – this was charted and given approximately 2-3 doses during this time. The GP noted his discussion with the daughter on the withdrawal of food. After this discussion food was brought to the room with staff unaware of the decision in the residents' record – this situation frustrated the family as nobody seemed to know what was happening. (Linked to 1.1.9.1, 1.1.3.7, and 1.1.13.1) Overall the resident's clinical file revealed that palliative cares were not initiated and delivered. The complaint issues were substantiated from the information gained. With regard to the complaint regarding resident (C), on reading the progress notes there was no mention of the change in level of care for

	the resident from rest home to hospital level care. (Linked to 1.2.9.1). Assessments and care plan were not updated so staff could provide the increased level of care required. Staff reported that they were told they were to assist the resident more at handover and that her room now had to be cleaned. (Linked to 1.3.3.1 and 1.3.5.2). Evaluations are not being completed and subsequently care plans not updated. **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.
1.3.12.1 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** A generic Standing Orders sheet was placed in front of the medication folder for use by staff for all residents. Standing orders are required to be charted for each resident. A respite resident did not have a medication chart; staff were giving medications from a pharmacy list brought in with the resident of current medications, no dosage or times etc. This resident had not been seen by her GP since admission, as her own GP was not available to visit the facility. **CAR:** Ensure 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.
1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	**Finding: Partially Attained** Evidence of one RN assessed as competent with medication administration. Other RNs competency for medications have not been carried out. **CAR:** Ensure all RNs 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, if the ingredients for what was stated are not available (this is a frequent occurrence), tinned baked beans or spaghetti are substituted at the tea meal. HCAs have to heat the tea meal and serve, they has been no training for this role. Food is prepared hours ahead of time (the cook works until 1430 hours) and some menu items provided are not suitable for reheating. There was no monitoring of food temperatures for meals. Residents' family and staff complained about the tea meal, for example one small sausage roll for tea, with no fruit etc. Food wastage from meals was not monitored and staffs were unsure of required portion size for meals. There was a winter and summer menu and the winter menu was in use, however there was no evidence of dietician review the content of the menu at the facility. **CAR:** Ensure that all nutritional need of residents is in line with guidelines appropriate for residential aged care.
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 cost of ingredients impacted on what was purchased. Some items were too expensive to purchase for the menu, and were not ordered by the service manager, as a set budget had to be complied with. Trays delivered to the residents are left uncovered sitting until staff can feed residents. With the low number of staff and the high number of residents requiring assistance to be fed, the meals go cold. Staff are

	called away to answer bells leaving the lounge unattended while residents are eating. Dining rooms do not appear to be used, as there is too few staff to monitor these areas. The kitchen cleanliness was poor, high cleaning had not been carried out inclusive of the fan and there were food scraps under the freezer, and an ant infestation, for which ant poison was being used. **CAR:** Ensure all aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply is within current legislation, and guidelines.

Safe and appropriate environment

Standard/Criteria	
1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.	**Finding: Partially Attained** The main commercial washing machine has been out of order for three to four months and staff have been using heavy duty washing machines for all dirty linen including heavily soiled linen. The provider has neither repaired nor replaced this commercial washing machine. There is no clean space available for sorting and folding clean clothes and linen. Laundry duties are carried out by HCAs and there is no oversight by the clinical infection prevention and control coordinator or staff training, (Linked to 3.1.1). There has been no monitoring of laundry processes for effectiveness. Supplies of cleaning products used by staff at the facility are not always in stock, and staff have to wait for the service manager to buy domestic products from a local shop. **CAR:** Ensure the methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness, and are available and working for staff use.
1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	**Finding: Partially Attained** Chemicals are stored in open sluice rooms, a sluice room sign on one door stated it was to be locked. As it was open during the inspection the door was locked by the acting nurse manager and staff were unaware of the key pad code to open the door again, a second sluice room had the door left in the open position. **CAR:** Ensure chemicals are safely stored and that only staff have access to them.
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** Fire exits were blocked with equipment and fire extinguishers and hoses had not been regularly checked. There were insufficient food and water supplies stored at the facility for an emergency. **CAR:** Ensure that fire exits are not blocked and that all fire equipment is routinely checked and tested. 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	**Finding:** At this inspection the bells were tested, and staff answered within two

system' is available to summon assistance when required.	minutes.

Restraint minimisation

Standard/Criteria	
2.2.3.1 The need for continued use of the restraint is continually monitored and regularly reviewed, to ensure it is applied for the minimum amount of time necessary.	**Finding: Partially Attained** The review of restraint consent and monitoring could not be evidenced as having been regularly carried out. The restraint coordinator has no hours allocated for this role and no training has been provided and the RN is a new graduate. **CAR:** Ensure that restraint consent and review is carried out at regular intervals.

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 Infection Prevention and Control clinical coordinator is a new graduate RN and has no access to senior clinical oversight. There are no specific hours allocated for this role and no external training has been provided. The service manager (non-clinical) ensures that monitoring occurs and reports to the general manager however there is no senior clinical oversight at that level of the organisation. Although statistics on infections are monitored, there is no evidence of corrective actions or improvements occurring from this process. There is no risk minimisation for cross infection of staff working across the different roles of caring, kitchen and meal preparation and laundry. Examples of this are: • linen is stored on the floor in linen cupboards and clean towels are stored in open containers next to dirty linen in the bathrooms • care staff fit the laundry work into any spare time and often the soiled laundry backs up for 24 hours and causes the smell to permeate that area of the facility • equipment such as hoists and commodes are not kept in a clean state. • The cleaning of the laundry and kitchen is not attended to. **CAR:** Ensure accountability for infection control matters is held by a senior clinical manager with reporting through to senior management. Minimise risk regarding cross infection. Ensure the Infection Prevention and Control clinical coordinator has external specific training for the role.

Summation meeting

A summation meeting was attended by: XXX XXX, Temporary Clinical Manager; XXX XXX,

Owner; XXX XXX, Owner; XXX XXX, General Manager; XXX XXX, Senior Advisor, HealthCERT; and XXX XXX, Senior Advisor, 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. The process of the development of an inspection report was explained and that this report when final would be published on the Ministry website.

Cressida Eversleigh Limited is required to take the above corrective actions to improve compliance against the Health and Disability Services Standards. On-going monitoring will be undertaken by Waitemata DHB and the Ministry of Health.

Conclusion

The unannounced inspection was as a result of complaints received. The focus was on whether Cressida Eversleigh Limited was meeting the Health and Disability Services Standards relevant to the complaints. The inspection found that the complaints were substantiated.

The following were the outcomes from the inspection.

Resident rights:

- There is no staff training or support in abuse/neglect for staff following a substantiated complaint.
- There is no resident/family meetings or involvement in the care planning process.
- The documentation of advanced directives and resuscitation is not clear and the current forms are confusing.
- There is an initial response sent out to complainants, however no investigations have occurred and there were no corrective actions or learning for staff following complaints. The number of complaints received over the past few months is high for a small facility. The complaints register is not up to date, actions are not being taken and complaints are not being managed within the policy time frames.

Organisational management:

- Authority, accountability and responsibility for the provision of service are not in place. Clinical managers have to seek approval from a non-clinical general manager or owners. There is a lack of differentiation between governance and management - this needs to be clearly defined in job descriptions.
- There is no clinical input at governance level into decision making which affects all levels of service. The facility and clinical manager roles 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 is not being managed, understood or implemented by service providers.
- There is insufficient appointment of appropriate service providers to safely meet the needs of consumers.
- There is poor staff uptake of education, evaluation of education and staff orientation.
- Progress notes are not written in an accurate and timely manner.

Continuum of service delivery:

- The lack of updating of assessments results in care plans that are not current.
- Resident/family involvement in the development of care plans was not evident.
- Care plans are only reviewed at the required six monthly interval and do not reflect changes in acuity or events requiring short term care plans or alteration in care.
- Activity plan goals are not met, reassessments of activity goals are not carried out.
- The medicines management system is not always implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation.
- The menu plan is not followed, health care assistants have to heat the tea meal and serve. They have no training for this role and there were issues regarding food being prepared hours ahead of time and no monitoring of food temperatures.
- There was a winter and summer menu and the winter menu was in use, but there was no evidence of dietician review and report concerning the content of the menu at the facility.
- Some items to meet the menu were not ordered by the service manager, as a set budget had to be complied with.
- Trays delivered to the residents are left standing uncovered until staff can feed residents.
- The lounge is left unattended while residents are eating, with too few staff to monitor these areas.
- The kitchen cleanliness was poor and high cleaning had not been carried out (including the fan). There were food scraps under the freezer and an ant infestation, for which ant poison was being used.

Safe and appropriate environment:

- The provider has neither repaired nor replaced the commercial washing machine, and there is no clean space available for sorting and folding clean clothes and linen.
- Laundry duties are carried out by health care assistants and there is no oversight by the clinical infection prevention and control coordinator or staff training.
- There has been no monitoring of laundry processes for effectiveness.
- Chemicals are not safely stored so that only staff have access to them.
- Fire exits were blocked with equipment and fire extinguishers, and hoses had not been regularly checked.
- There was insufficient food and water supplies stored at the facility for an emergency.

Restraint minimisation:

- There was no evidence that a review of restraint consent and monitoring had been regularly carried out.
- The restraint coordinator has no hours allocated to this position, has had no training provided, and is a new graduate with no senior clinical oversight.

Infection prevention and control:

- The Infection Prevention and Control clinical coordinator is a new graduate RN and has no senior clinical oversight, no specific hours allocated for this role and no external training has been provided.
- The service manager (non-clinical) ensures that monitoring occurs and reports to the general manager and governance. However, there is no clinical role at that level of the organisation.
- Although statistics on infections are monitored there is no evidence of corrective actions or improvements occurring from this process.

- There is no risk minimisation for cross infection of staff working across the different roles of caring, kitchen and meal preparation and laundry.

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: 1.1.3.7, 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, 1.3.3.1, 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, 1.4.6.2, 1.4.6.3, 1.4.7.1, , 2.2.3.1, 3.1.1 as identified in the Inspection Report must be submitted to the Waitemata District Health Board by 30 August 2012.

2. HealthCERT may elect to carry out an unannounced 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
- 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.