Final Inspection Report

Johnsonvale Home Trust

Date of inspection: 11 September 2009

HealthCERT
Quality & Safety
Sector Accountability and Funding
Ministry of Health

Contents

Undertaken	**11 September 2009**
File Ref:	**WJO02**
Provider:	**Johnsonvale Home Trust**
Contact Person:	**XXX XXX, Manager**
Premise:	**16-18 Earp Street, Jonsonville, Wellington**

Executive Summary

History:

Johnsonvale Home Trust is certified to provide Hospital (geriatric) care services for a period of three years, expiring on 21 December 2011, and Rest Home care services for a period of three years, expiring on 5 September 2010.

The provider applied for certification (Rest Home) in September 2004 and was certified for three years. In the 2004 (Rest Home) certification audit there were seven partially attained criteria identified which required corrective action reporting, these were completed satisfactorily. In the 2007 (Rest Home) recertification audit there were two partially attained criteria identified which required corrective action reporting, these were completed satisfactorily.

A routine surveillance audit was carried out (Rest Home) on 2 April 2009, no corrective actions were required.

The provider applied for Hospital certification in December 2006 and was certified for two years. In this certification audit there were fifteen partially attained criteria identified which required corrective action reporting, these were completed satisfactorily.

In the 2008 (hospital) recertification audit there were nine partially attained criteria identified which required corrective action reporting, these have been completed satisfactorily.

A surveillance audit is due to be carried out prior to 21 June 2010 for Hospital services.

There have been contacts from the provider throughout 2008 and 2009 regarding the inability to meet the requirement of 24 hour registered nurse coverage for the hospital. The provider has covered these gaps by use of agency staff and managerial staff.

Previous Recent Complaints

Rest Home: March 2009 - Complaint about the conduct of the Manager. The complainant requested that no action be taken. CLOSED

Hospital: July 2009 - Complaint from XXX XXX about the quality of care given to her mother. OPEN

Nature of current complaint

The Ministry of Health received a complaint from Ms XXX XXX about the care provided to her mother, XXX XXX, a resident at Johnsonvale Home.

In summary, Mrs XXX alleged that:

- Some staff have behaved aggressively and arrogantly towards XXX XXX and her family
- The family did not receive a response from Johnsonvale following a complaint that XXX XXX had not been suitably prepared for a day out
- The family was not advised that XXX XXX had scabies
- Staff were not helpful when XXX XXX's teeth went missing
- The family was not suitably consulted about the need to cut off XXX XXX's rings
- Wheelchair foot rests are contributing to residents' falls and injuries
- XXX XXX's family were advised that it would be necessary to pay for a special bed to prevent their mother getting out of bed at night.

In addition the Ministry reviewed information requested and received from the provider in relation to this complaint. It was noted that the facility had a high ratio of resident's falls predominantly in the afternoon/evening period.

Further information (DHB/HDC)

On 1 September 2009, XXX XXX, Portfolio Manager, Capital and Coast DHB, was contacted , she had no further information concerning the provider, but considered a HealthCERT unannounced audit to investigate the complaint was required.

Service Description

Johnsonvale Home Trust – provides Aged Residential Care Hospital & Rest Home services. The occupancy and capacity is outlined below:

Area	Occupied	Capacity
Hospital	26	25
Rest Home	22	40
Dementia	NA	NA
Total	**48**	**65**

Reasons for the inspection

The purpose of the inspection was to determine whether health care services being provided by ***Johnsonvale Home Trust*** are being provided in compliance with section 9, 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 Health and Disability Services (Safety) Act 2001 (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;

(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 Senior Advisors, XXX XXX HealthCERT and XXX XXX 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 resulted in systems 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 utilising the following methods:

- Interview with Manager
- Interview with Care Manager
- 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 audited.

Limitations

The scope of the inspection was the issues raised in the complaint, and was widened as a result of issues noted on the tour of the facility.

Entry Meeting

XXX XXX, HealthCERT; XXX XXX HealthCERT; XXX XXX (Care Manager) were present at the entry meeting. The Manager was absent as she was on sick leave. XXX XXX contacted manager via phone. The letter of entry was read out to her in the presence of XXX and then handed to XXX.

The meeting commenced at 8:00am and ended at 8:30am.

The introduction meeting covered the following points:

A proposed agenda for the day was discussed on the telephone and again with XXX. It 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. XXX offered to take Senior Advisors on a tour of the facility.

Summary of Inspection findings

Non-compliance with the Health and Disability Services Standards specific to the complaint are reported in the following summary.

The scope of the inspection was widened to include findings from the tour of the facility and interviews with staff.

Conditions of Certification – Breach

The provider has failed to notify the Director-General of Health regarding the change in bed capacity for the kinds of services being provided at the time of issue of the certificate. The provider currently has two extra hospital residents (27 not 25) funded through ACC. This is a requirement as per the provider's Schedule conditions of certification.

Corrective Actions:

The provider must complete a Notification of (proposed) Increase in Capacity of a Certified Service Form. This form is to be submitted to HealthCERT by 1 November 2009.

Consumer Rights during Service Delivery - Standard 1.1

1.1.3.7 – Partial attainment

There was evidence in clinical notes, minutes of Staff, Health & Safety, Infection Control and Management meetings) and at staff interview of resident to resident abuse due to the dementia levels both within rest home and hospital residents.

It was noted at the time of the inspection that at least two residents may be in need of a NASC reassessment concerning placement. Also the Manager's letter of response to MOH initial information request of 13 August 2009, identified five residents as wandering.

[Note: The NASC review after the inspection resulted in one resident being identified as requiring specialised psycho geriatric care and one rest home resident requiring hospital level care].

At interview six of seven staff stated they felt intimidated, and verbally abused at times by the Manager, but do not complain concerning this, as there is no process for them to do so without fear of retribution.

In May there was a written complaint concerning staff to resident abuse and this was discussed at the May staff meeting. It was also noted that an agency staff member had made phone calls on a resident's phone to 0900 sex lines and called cell phone numbers during working hours. This was consequently dealt with by the provider.

In the incident reporting, there were instances of resident to resident aggression/ abuse, noted in more than one month, over a period of six months.

In August bullying in the workplace was also identified as a concern to be addressed at the staff meeting by the Care Manager.

With regard to the complaint, staff were able to verbalise encounters between the complainant and the Manager, as well as with others, of a "defensive, aggressive, arrogant" behaviour pattern from the Manager, that was referred to within the complaint.

The complainant was specific in her instances of contact and interaction, both in person and by phone, and had also discussed this with her sister.

Staff training for abuse and neglect in aged care was last held in 2006, there was minimal reference to this subject within staff training for cultural awareness in 2007. Attendances at staff training sessions are low compared to total staff numbers.

Corrective Actions:

Ensure that education programmes for service providers are repeated at appropriate intervals to maintain knowledge regarding abuse and neglect in aged care, and that there is an increased uptake of staff attendance.

Ensure mechanisms to identify and respond in a timely manner to incidents of abuse or neglect. This to include but not be limited to resident to resident abuse which is not a normality within residential care.

*Ensure that resident's have current needs assessments that verify their suitability for the level of service they are receiving.

Ensure staffing is sufficient to provide supervision of and diversional therapy for residents that have been identified as having challenging behaviour where aggression may be a feature, and that these residents have a full multidisciplinary reassessment.

Ensure staff are trained in identifying triggers to challenging behaviour and managing challenging behaviour where they actively intervene to minimise risk to others.

Note:* Reporting required at one month

1.1.8– Partial attainment

Incident reporting systems are not linked to quality improvements, and an extremely high fall rate was noted (300 in six months). Accident incident forms did not have recommendations other than generalisations such as "continue monitoring" or "regular checks". There was no evidence of evaluation of these recommendations, multidisciplinary reassessment or implementation of assessment tools, leading to changes within the care plans.

Human resource management particularly supervision, mentoring and professional development for all levels of staff is not well developed.

Continuity of care based on best practice, was not evidenced particularly concerning assessment (pain; falls) and care planning.

With regard to the complaint, evidence best practice was not carried out concerning fall management, and there was no linkage to quality improvement

Corrective Actions:

Ensure that clinical staff are given appropriate training or have access to current clinical expertise, e.g. Challenging Behaviour, managing residents with high fall risks.

Ensure an in-service training plan has been documented and organised that reflects the training needs of staff. This should include but is not limited to training needs and mechanisms to demonstrate competence in the delivery of care associated with corrective actions generated from this inspection and a linkage to quality improvement.

Ensure there is an education and training plan developed for Registered Nurses for their professional development, e.g. wound care updates.

1.1.12 –

With regard to the complaint, it would not always have been possible to transport the resident to a telephone and at times of the day (particularly in the afternoon/evenings when there is less staff), or due to the position of the resident's room within the facility the portable hand set telephone may not have been able to be used.

Recommendation:

That all staff inclusive of agency staff are aware of these difficulties and make every effort to ensure contact is maintained, and that open disclosure to the caller is maintained concerning any difficulties regarding telephone access.

1.1.13.3 – Partial attainment

A complaints register is in place, however the complaint process and register documentation is scant, and not all complaints are listed. There is no linkage to quality improvement, following analysis and evaluation, and no record of actions to obtain resolution and quality improvement were evidenced on the register.

Although there is a complaint policy in place not all complaints are recorded in the register. One specific example is the written complaint regarding staff abuse of a resident in the May Staff Minutes which was not recorded in the register. The regular concerns / complaints concerning residents being ready for outings on time and with clean equipment raised in relative interviews, were not recorded. Thus no evidence of addressing these complaints was found, nor any quality improvements.

Staff interviewed did not use the complaints system themselves and stated that they knew of relatives who felt that it was not worth complaining because of the difficulty experienced when doing so due to the Manager's attitude / approach to dealing with complaints.

With regard to the Mrs XXX's complaint, other resident's relatives/visitors also stated that they received no reply to concerns that residents were not always ready for outings/ church services and were sometimes kept waiting while staff, prepared the residents.

Corrective Actions:

Ensure all complaints received irrespective of whether they are from staff, residents, relatives or friends, in whatever form, are actioned in accordance with the facility policy and comply with the Code of Health and Disability Consumers Rights for complaint management. Review all outstanding complaints to ensure they are managed appropriately and outcomes linked to corrective action planning and service improvement, and that these details are noted on the complaints register.

Ensure that staff have access to an independent and impartial advocate if they wish to make a complaint (either written, verbal or anonymous); and that these are responded to in a timely manner, and noted on the complaints register. Staff complaints process needs to be reflected in the facility policy.

Link the complaint management process to the quality and risk management system where complaints and their investigations can contribute to service improvement.

Organisational Management - Standard 1.2

1.2.3– Partial attainment

The provider has a current 2009-2010 Business and Quality and Risk Management Plan, however this appears to be a "roll over" from previous years, and is not specific to the current year, (2007/8 year plan is highlighted and referred to), nor does it contain the list of KPIs set down by the Board for the current year, these are contained in a separate document. The focus is on business risk more so than quality improvement and clinical risk. There is no corrective action plan addressing areas for improvement, or an equipment replacement schedule.

The Manager reports quarterly to the Board and the August report is a one page summary. The only reference to health and safety was around staff hours lost due to injury, but no detail on patient incidents and associated risks. There is no process to evaluate and measure against implementation.

Consumer participation is achieved via a satisfaction survey of residents, however participation/ response is less than 50% , and an advocate employed by the facility assists those residents unable to complete the questionnaire. It was noted that a number of these residents have cognitive impairment.

No staff satisfaction survey is carried out, nor is there a confidential exit interview process, the Manager could see no reason for these to occur, and stated that staff can speak out at the regular staff meetings.

Corrective Actions:

Developing corrective action plans where a deficit has been identified and requires action to prevent or limit the risk of recurrence

1.2.4– Partial attainment

Staff are vigilant in completing forms. There were nearly 600 incidents documented in 2008, of which >50% were falls. Of those falls (300), a third resulted in some injury to the resident.

Staff complete incident accident forms and these are then reviewed by the Manager, however there is incomplete closure of the quality loop. There had not been analysis of recorded incidents and accidents to identify trends to inform quality improvement either at an individual or whole of service level. There is collation of incident and accident reports, but this does not formally include analysis against trends associated with individual residents or documented action plans to contribute towards improvement or avoidance of recurrences. There is no evidence of analysis of accidents translating into review of individual care plans.

There is no documentation of corrective action planning or a close out process where corrective actions have occurred or process for ongoing monitoring of implementation of improvements.

It was evidenced that EPOA/relatives were routinely informed or messages left for them following an incident/accident, however there was no correlation to the resident's doctor being notified of falls etc., unless injury was suspected.

In one in instance a resident had complained of back pain following a fall but there was no evidence of the doctor being notified of the fall. The resident was commenced on pain relief for this, (panadol), as a PRN dosage by nursing staff. At the patient's routine 3 monthly check the doctor noted that the resident now had back pain and that PRN panadol was not sufficient and prescribed different pain relief. The doctor did not note a recent fall, nor was there any notation within the clinical notes that would link the fall to the commencement of the back pain, and need for pain relief, for the doctor to assess.

With reference to Mrs XXX's complaint , it is documented on 25 June 2009 that the complainant's sister was notified that Mrs XXX was to be treated for scabies, but no record that the relative was notified 9 March 2009 when an earlier treatment was given.

Corrective Actions:

Ensure that incidents, accidents and other untoward events are analysed in a timely manner

Undertake trend analysis associated with individual residents and trend analysis associated with the facility as a whole, linking the analysis back to a quality improvement system with regular reporting to the Board.

Ensure each resident's file verifies that all relevant assessments have been completed and where appropriate further assessments are scheduled to occur as part of monitoring the progress of the resident.

Document adverse, unplanned or untoward events in order to identify opportunities to improve service delivery and manage risk.

1.2.7– Partial attainment

The facility currently has 3 FTE care giving staff vacancies; these vacancies, sick and annual leave are covered by facility staff working extra shifts and a high usage of agency staff.

In regard to Registered Nursing staff there are four shifts in a fortnight not permanently filled.

On review of the roster there were only 7 days when agency staff were not used over a period of two months (July/August).

The facility layout of five wings (including upstairs wings), plus intermixing of hospital and rest home residents throughout, does not allow for staff to be rostered to specific hospital care or/ rest home care.

This system therefore does not allow for the staff ratio for Rest Home or Hospital care to be easily determined.

In the afternoon period the staffing is low and there is often a higher number of agency care givers on that shift. This is also the "peak" time for falls/injuries within the facility. Staff report that staff levels can be insufficient, and that it is difficult working with agency staff and orientating new staff.

An education programme is in place for staff, however this does not identify specific needs of residents i.e. challenging behaviour; skin integrity, and these sessions are poorly attended by staff.

1.2.7.3 – Partial attainment

The activities staff for the facility consists of a Diversional Therapist-in-training who works 77 hours per fortnight and a part time person who works 11 hours per fortnight, and the actual time spent with residents is limited due to the preparation time needed for planning and documentation for these activities. The total activities hours worked per fortnight is 88. This represents for the current 48 residents, 1.8 hours per resident per week, **excluding** any preparation, assessment, documentation or planning time.

This time is spent on group sessions with little one on one time for ill or cognitively impaired residents.

With reference to Mrs XXX's complaint, the resident was not in a specific "hospital area" but in a room off the end of a corridor, some distance from the nurses' office.

Corrective Actions:

Review registered nursing and care staff hours to ensure that consumers receive timely, appropriate and safe service from suitably qualified/skilled and/or other experienced service providers.

Ensure the competency of service providers, by identifying opportunities to improve service delivery; identifying education needs and associated time frames to meet these, ensuring clinical staff are supported in their professional development.

Ensure that education needs are identified for all staff (this to include RN staff) and associated timeframes to include best current practice presented by qualified personnel, i.e. wound care; challenging behaviour.

Revise allocation of hours for diversional therapy, and diversional therapy staff, to better meet the needs of residents.

Recommendation:

A reconfiguration of services is recommended to ensure that consumers receive timely, appropriate and safe service from the provider, allowing for specific registered nurse oversight of hospital residents. This would also allow for accurate and safe staffing ratios to be formulated for hospital residents.

1.2.8 – Partial attainment

The Home is staffed by a Manager (RN) who works at least two days per fortnight as the clinical RN. A Care Manager (RN) who works five days per week as the hospital and rest home morning shift RN.

The Care Manager also has responsibility for the roles of Infection Control Officer; Restraint Coordinator; and Relieving Manager (staff commented that the Manager has had considerable leave days this year). There are no specific hours allocated for these roles, and

no replacement RN hours for when the Care Manager is managing the Manager's role temporarily in addition to their own role.

The Care Manager also has on-call after hours responsibility, on alternate weeks with the Manager.

The physical layout of the facility and mix of hospital /rest home residents throughout the wings limits the time available of the Care Manager for mentoring and supervision of care staff.

Corrective Actions:

Revise the allocation of staff to ensure suitably qualified staff are rostered and sufficient staff are on duty to provide competent and safe care in order to meet the needs of individual residents

Continuum of Service Delivery - Standard 1.3

1.3.4 – Partial attainment

There are a number of nursing assessments with the clinical notes, but not all are updated.

Staff were observed assisting a resident to mobilise, but the manual handling observed was not safe for staff or resident. A transfer belt was not used, and the Care Manager stated the resident has not been assessed by a physiotherapist. (There is a contract physiotherapist, but this option had not been used).

In regards to the complaint, the falls risk was identified by assessment for Mrs XXX, but no specific interventions were noted to reduce these. Again no assessment for mobilising had been carried out by a physiotherapist.

Corrective Actions:

Ensure clinical and care staff seek appropriate information and access a range of resources to enable effective assessment and care.

Ensure coordination of services for residents includes a multi-disciplinary approach where appropriate. This should include but is not limited to:

- Referral to an appropriate allied health professional (such as a Physiotherapist) to assist with specialised assessments and to support decision making where a resident is not progressing as expected and would benefit from a multidisciplinary approach to plan services
- Involving family/whanau in planning and regular reviews with the resident

Ensure each resident file will verify that all relevant assessments have been completed and where appropriate further assessments are scheduled to occur as part of the review of the resident.

1.3.5 – Partial attainment

The resident notes are not integrated. An "ADL" plan was in each wardrobe, with basic information, that the Care Manager updated, but these did not include the detail required to provide staff with the knowledge on individual interventions, such as falls interventions. Care giving staff did not refer to the care plan on a regular basis. There was no evidence of interdisciplinary team involvement or family/whanau involvement in care planning.

With regard to the complaint, EPOA/family had not always been involved in informed choice of treatment and support options, i.e. hip protectors, sensor mats/pads, lap belts. When this involvement did occur the family were requested to purchase the limb protectors for the resident, this was some considerable time after the resident had started to incurr lower leg skin tears. These limb protectors are not individual specialised equipment and can be held in stock so that any resident presenting with fragile skin with a risk of bruising or skin tears can have immediate access.

Corrective Actions:

Ensure service delivery plans are individualised, accurate and up to date, and that service delivery staff are informed of the changes.

Ensure that individual needs; outcomes and /or goals are documented to serve as the basis for service delivery.

Ensure care plans adequately reflect the interventions required to meet the assessed needs of residents and their associated goals.

Ensure that clinical files for residents are integrated. This should include but is not limited to having current care plans, progress notes, assessments and incident or accident forms held as one file.

1.3.6– Partial attainment

There were a number of clients who wandered and these residents had not been re-assessed to review support need levels. Residents who were aggressive towards other residents had no referrals to the GP, other health professionals, or to the NASC for reassessment regarding appropriate placement.

With regard to the complaint, the resident had not had a physiotherapy assessment for mobilising, and continued to sustain skin tears to her lower limbs during the process of mobilsation / cares. Although a frequent fall risk was assessed, no informed consultation for the use of safety equipment for example; pressure sensitive mats, ultra low beds was documented in her file.

The resident also developed pressure (sacral) area, and a short term care plan was developed, but when this became chronic the details were not transferred to the main care plan, nor was there a referral to a wound care specialist nurse (DHB, note: a consultation fee is charged to the facility for this service and the service is available to residential care facilities).

Corrective Actions:

Ensure referrals to allied health specialists are made in order to meet resident assessed needs and outcomes and for consultation and advice.

1.3.8– Partial attainment

The care plans are evaluated within the folder, but there is a two tier system for care planning with the use of a ADL care plan. The two plans are not integrated and the ADLs do not have individual interventions in relation to resident's requirements. The care staff work from the ADL which is in the resident's room.

Goals are not set. The relationship between the assessment and planning is not clearly demonstrated in documentation. For example a higher risk of falls did not correspond with a goal to prevent falls and associated interventions. Incident records were kept separately each month from the clinical file and not collated at any point.

Corrective Actions:

Ensure that where progress is different from expected, the client is assessed and where necessary the care plan is reviewed to reflect the changes and then implemented.

Ensure a documented evaluation of care indicating achievements towards identified goals occurs at scheduled intervals or in response to a change in need of a resident.

1.3.9– Partial attainment

There were rest home residents identified through this investigation where the needs of the resident were likely to be dementia services/ hospital care. These residents had not been identified and had not been referred for a needs assessment.

Corrective Actions:

Ensure appropriate facilitation of referral to other services where this is indicated including referral to the Needs Assessment Coordination Service.

1.3.12– Partial attainment

A medication round was observed. At this round, medications were signed for prior to being given and left on the medication trolley. At interview staff also commented that medications were also left out by the person responsible for medication administration or given to other care givers to administer.

Corrective Actions:

Ensure safe and appropriate administration and disposal of medicines in order to comply with legislation, protocols and guidelines.

Ensure service providers responsible for medicine management are competent to perform the function for each stage they manage.

Safe and Appropriate Environment - Standard 1.4

1.4.2.3– Partial attainment

The facility has 5 ultra low beds that lower to the 19cm height, reducing falls injury. These beds had been donated by past residents' families. Residents were evidenced as high risk for falls and incident accident rates concurred with this, (300 in six months). There was also a high incidence of skin tears/injury to limbs, however resources for limb protectors were not

evidenced. Non-slip surfaces were not evidenced in resident's rooms, where lino was installed.

The 2009-10 business plan does not allow for replacement equipment scheduling taking into account consumer safety, needs and ability.

In relation to the complaint, it had been "suggested" the family purchase an ultra low bed (lowering to a height of 19cm). The bed for the resident is currently an adjustable height bed, but does not lower to that level. Also the resident has an air undulating mattress,(necessary for her skin integrity) which raises the bed height further. This creates a higher risk immediately that did not appear to be noted.

There was an additional mattress to use on the floor to prevent injury from falls (fall out mattress). The room had lino in place that was not non-slip. The resident was being cared for in a smaller room, making use of a hoist by two assistants difficult to maneouvre, due to the confined space, as furniture was built into the room, and unable to be moved. In the non use of a hoist two staff would have had to assist the resident to stand and transfer into a toilet/wheel chair, in the same circumstances. This could have contributed to the injuries/skin tears sustained.

Corrective Actions:

Ensure that there is sufficient safety and enabling equipment for staff to use, when the a resident has been assessed as high risk, from, for example, falling..

Ensure that an equipment replacement programme is carried out per a plan and that this is reviewed at least annually.

Ensure that amenities, fixtures, furniture, and equipment are selected, located and installed with consideration to consumer needs and abilities, and resident safety.

1.4.2.4 – Partial attainment

The majority of hospital residents requiring full assistance with activities of daily living are cared for in smaller rooms, (there are a total of 4 rooms that have been altered to increase door size and room size, one of which is used for an ACC funded hospital resident over and above the 25 hospital capacity beds, noted at certification).

This situation makes usage of a hoist by two assistants difficult to manoeuvre, especially as furniture is predominantly built into the room, therefore is unable to be moved. The furniture also juts out into the room and does not have rounded edges.

In the non use of a hoist two staff would have to assist the resident to stand and transfer into a toilet/wheel chair, in the same circumstances.

Potential for injury to residents and staff during these procedures is a high risk,. The small space in the rooms with built in furniture and walking aids, chairs etc., could contribute to residents sustaining skin trauma during a fall. The incident accident report data provided to the Ministry of Health for a six month period indicated that 60% of falls /injury occur in bedrooms.

Fire stop doors in corridors; room doorways and bathroom doorways are just within the requirements as per building code, and make manoeuvring wheelchairs and toilet chairs

difficult but not impossible. For an ambulance stretcher to fit though some corridor openings would also be difficult but not impossible, in the sitting position.

Corrective Actions:

Ensure the physical environment minimises the risk of harm, promotes safe mobility, aids independence, and is appropriate to the needs of the consumer group.

Safe Restraint Practice - Standard 2.2

2.1.2– Partial attainment

There was no evidence of collaborative assessment for restraint minimisation and use of enablers. Voluntary use of enablers was not supported by the manager, and staff were not supported in the procurement of enablers within the budget plan. The facility has one Lap restraint/ enabler.

Corrective Actions:

Ensure that all staff are aware of the the provider's restraint policy, and that all staff are aware of the clear lines of responsibility for restraint or enabler use.

Ensure that restraints if provided within the facility comply with accepted best practice and appropriate for individual client needs.

2.1.5 – Partial attainment

Prevention and/or de-escalation techniques for challenging behaviour are not skills that staff have had recent training for (last noted in 2006 with minimal inclusion in cultural safety in 2007), this is evidenced by a recent "lash out" by a resident, where staff were unaware of how to approach a resident presenting challenging behaviour; (training planned for late September this year). Staff also noted at interview that medication is used PRN to manage behaviour

Corrective Actions:

Residents requiring PRN medication to manage their challenging behaviour are monitored for therapeutic effect and adverse reactions and this is reviewed and documented.

Ensure appropriate facilitation of referral to other services where this is indicated including referral to the Needs Assessment Coordination Service.

2.2.1– Partial attainment

The facility was fully locked, and residents/visitors required assistance or a key pad number to exit via the entry/exit. This exit is also the one closest to the emergency assembly area. All garden areas were enclosed within the facility. The care manager stated that this was due to the facility having residents who "wandered", and that there were only a few residents who were able to leave the premises unattended.

Observation of clinical records showed that residents within the facility had been assessed by NASC as rest home or hospital level.

There were residents identified through this investigation where the needs of the resident were likely to be dementia services/ hospital care. These residents had not been referred for a review of their needs assessment.

Corrective Actions:

Ensure that egress to and from the facility is accessible to residents/visitors without requiring assistance or a key pad number to exit.

Summation meeting

A summation meeting was attended by XXX XXX HealthCERT; XXX XXX HealthCERT; XXX XXX, Manager; XXX XXX, Care Manager.

XXX thanked the facility 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 more information was required and photocopied information gathered needed further analysis. XXX noted that relatives interviewed had been complementary of the service, and that most staff were approachable. She confirmed that there would be findings against the Health and Disability Services Standards and these would be likely to include the following areas:

Consumer Rights during Service Delivery;

Organisational Management;

Continuum of Service Delivery;

Safe and Appropriate Environment;

Safe Restraint Practice

Key issues relevant to the complaint raised at summation likely to have corrective actions were:

Abuse:- Resident > Resident; Staff> Staff; Resident > Staff

Lack of Assessment with regard to Falls; pain; restraint; enablers; placement;

multidisciplinary review

Communication – Telephone access for non ambulant residents

Complaints Management – process; outcome and evaluation linked to quality improvements

Adverse Event Management – Corrective actions; outcomes; evaluation

Human Resources – Staff levels; skill mix ; staff development

Planning – Non integration of care plans; evaluation; multidisciplinary interventions; informed choice; goal setting

Medication – Safe practice of medication administration

Environment – Equipment; mix of hospital/ rest home residents; non slip surfaces; room size/egress

Restraint - Assessment; staff training; informed consent; locked facility.

Issues not relevant to the complaint raised at summation, not likely to have corrective actions, but recommended be addressed were:

Environment – Carpets in some bedrooms were stained; blocked fire exits; lack of high cleaning and day to day maintenance such as flickering lights.

Informed consent –EPOA to sign for residents deemed cognitively impaired (NOT advanced directives). Need to revise existing consents to ensure compliance.

General – oxygen cylinder safe storage; cleaning chemicals and medicated lotions left on corridor hand rails; open door to hot water cylinder cupboard; clean linen trolleys uncovered and one trolley in disrepair with flaking surface; clean linen stored next to uncovered soiled linen containers; Unused controlled medication to be returned to pharmacy.

Conclusion

Johnsonvale Home Trust 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 the Ministry of Health in conjunction with the District Health Board.

Additional Conditions

Additional conditions to be placed on the Certification Schedule

Pursuant to section 28 of the Health and Disability Services (Safety) Act, the Director-General of Health may attach any condition the Director-General thinks necessary or desirable to help achieve the purpose of this Act.

The following conditions are to be included on the certification schedule of Johnsonvale Home Trust:

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; 1.3.6; 1.3.9; 1.3.12; as identified in the Inspection Report must be submitted to the Director-General by 23 November 2009.
2. A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards: 1.1.3.7; 1.1.8; 1.1.13.3; 1.2.4; 1.2.7; 1.2.8; 1.3.4; 1.3.5; 1.3.8; 1.4.2.3; 1.4.2.4; 2.1.2; 2.1.5 as identified in the Inspection Report must be submitted to the Director-General by 23 January 2010.
3. A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards: 1.2.3 as identified in the Inspection Report must be submitted to the Director-General by 23 April 2010.
4. HealthCERT may elect to carry out a verification audit in relation to these corrective actions

5. 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.

Summary for Publication

The Ministry of Health carried out an unannounced inspection at Johnsonvale Home Trust, on 11 September 2009 in response to a complaint concerning the care provided to a resident.

The purpose of the unannounced inspection undertaken on 11 September 2009, was to determine whether health care services being provided by, Johnsonvale Home Trust are 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.

The relevant standards have been attained but with some criteria considered at inspection to be partially achieved, Johnsonvale Home Trust is required to undertake the following corrective actions to achieve those criteria.

Ongoing monitoring will be undertaken by the Ministry of Health in conjunction with the District Health Board including, but not limited to the submission of reports to the Ministry by 23 November 2009; 23 January 2010 and 23 April 2010, the requirement to have the actions verified at the time of the next audit.

Consumer Rights:

Ensure there are mechanisms put in place to identify and respond in a timely manner to incidents of abuse or neglect.

Ensure an in-service training plan has been documented and organised that reflects the training needs of staff and includes an education and training plan for Registered Nurses. Ensure that education programmes for service providers are repeated at appropriate intervals to maintain knowledge

Ensure staffing is sufficient to provide supervision of and diversional therapy for residents that have been identified as having challenging behaviour. Ensure staff are trained in identifying triggers to challenging behaviour and managing challenging behaviour.

Ensure all complaints received are actioned in accordance with the facility policy and comply with the Code of Health and Disability Consumers Rights for complaint management. Link the complaint management process to the quality and risk management system where complaints and their investigations can contribute to service improvement.

Organisational Management:

Develop corrective action plans where a deficit has been identified and requires action to prevent or limit the risk of recurrence. Document adverse, unplanned or untoward events in order to identify opportunities to improve service delivery and manage risk. Undertake trend analysis associated with individual residents and with the facility as a whole, linking the analysis back to a quality improvement system with regular reporting to the Board.

Review registered nursing and care staff hours to ensure that consumers receive timely, appropriate and safe service from suitably qualified/skilled and/or other experienced service providers. Ensure the competency of service providers by identifying opportunities to improve

service delivery; identifying education needs and associated time frames to meet these, ensuring clinical staff are supported in their professional development.

Revise allocation of hours for diversional therapy, and diversional therapy staff, to better meet the needs of residents.

Continuum of Service Delivery:

Ensure service delivery plans are individualised, accurate and up to date, and that service delivery staff are informed of the changes. Ensure that clinical files for residents are integrated.

Ensure coordination of services for residents includes a multi-disciplinary approach where appropriate.

Ensure clinical and care staff seek appropriate information and access a range of resources to enable effective assessment and care. Ensure each resident file verifies that all relevant assessments have been completed and where appropriate further assessments are scheduled to occur as part of the review of the resident. Ensure that individual needs; outcomes and /or goals are documented to serve as the basis for service delivery. Ensure referrals to allied health specialists are made in order to meet resident assessed needs and outcomes and for consultation , advice and where required, reassessment.

Ensure safe and appropriate administration and disposal of medicines in order to comply with legislation, protocols and guidelines. Ensure service providers responsible for medicine management are competent to perform the function for each stage they manage. Residents requiring PRN medication to manage their challenging behaviour are monitored for therapeutic effect and adverse reactions and this is reviewed and documented.

Safe and Appropriate Environment

Ensure that the physical environment minimises the risk of harm, promotes safe mobility, aids independence, and is appropriate to the needs of the consumer group.

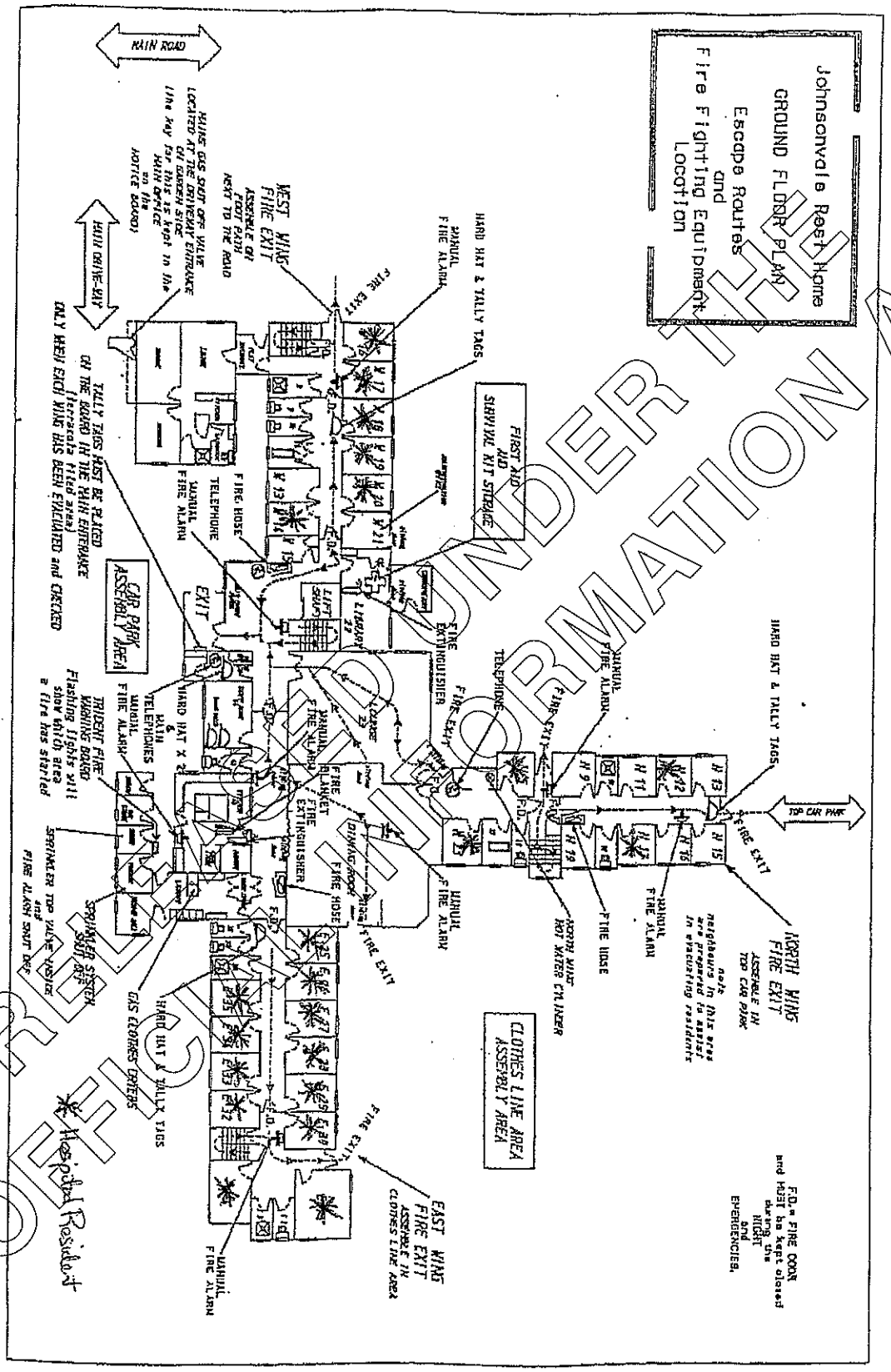
Ensure that an equipment replacement programme is carried out per a plan and that this is reviewed at least annually.

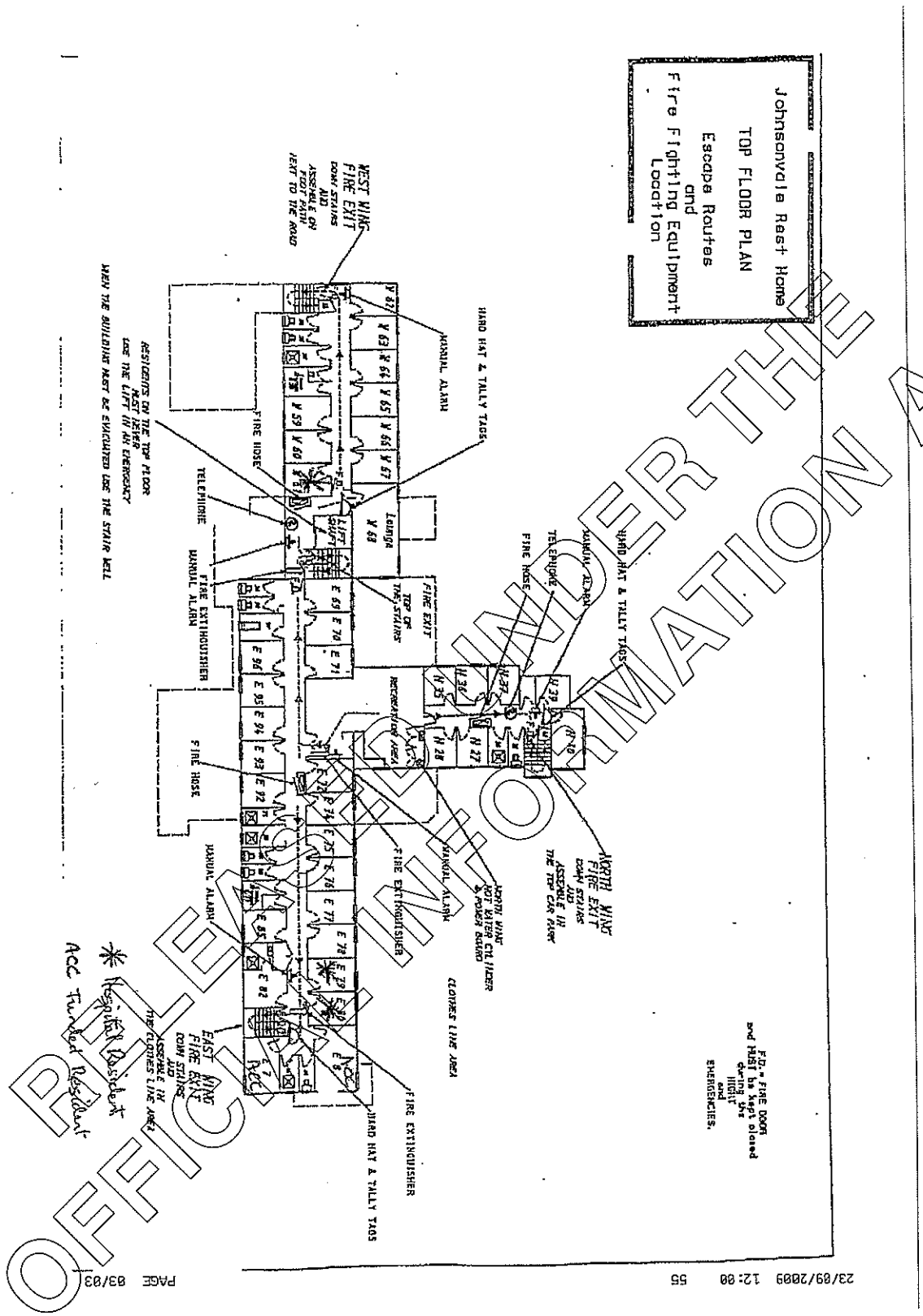
Safe Restraint Practice:

Ensure that there is sufficient safety and enabling equipment for staff to use, when a resident has been assessed as high risk.

Ensure that egress to and from the facility is accessible to residents/visitors without requiring assistance or a key pad number to exit.

Appendix 1: Plan of Facility





Appendix 2

Documents requested

- Staffing and skill mix policy
- Rosters for the last four months
- Manager and care Manager position descriptions
- Abuse and Neglect Policy
- Management of Challenging Behaviour Policy
- Complaints management policy
- Complaints register for the last six months
- Clinical Assessment Tools in current use
- Staff orientation policy and process
- Staff training records and in-service training programme
- Quality and risk management plan
- Emergency Response Policy
- Incident and accidents records for the last six months
- Open Disclosure policy
- Policy for service delivery
- Infection control policy
- Pain management policy
- Policy on medication management
- Health and Safety policy
- Falls management policy
- Policy and procedure for the safe use of restraints
- 2009/10 Business Plan and quality & risk management plan
- Minutes of meetings
- Resident files
- Completed resident satisfaction survey
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