Inspection Report

North Waikato Care of Aged Trust Board Inc.

Kimihia

Huntly

31 March 2009

HealthCERT

Quality & Safety

Sector Accountability and Funding

Ministry of Health

Contents

Undertaken	**10 March 2009**
File Ref:	**WN008**
Provider:	**North Waikato Care of Aged Trust Board Inc (Kimihia)**
Contact Person:	**XXX XXX (Manager)**
Premise:	**76 Rosser Street, Huntly**

Executive summary

HealthCERT received a complaint from Health consumer services (an advocacy service) on behalf of a power of attorney for a resident at Kimihia Rest Home on 11th February 2009, and following this further concerns were raised on 26 February by the Northland District Health Board.

The complaint relates to the care of a resident with dementia and alleges:

- Physical abuse between residents
- Inappropriate administration of prn (as needed) medicines
- Lack of appropriate first aid and follow-up care following injury
- Insufficient falls management
- Unexplained weight loss
- Inappropriate ongoing placement of a resident in dementia care when hospital level care was required
- Over charging the DHB for hospital level care when rest home care was being provided
- Neglect in providing care

The complaint is supported by a letter from a psycho-geriatrician to the general practitioner for this resident who noted concern that the resident had not been referred to mental health services for older people sooner or for fracture clinic appointments and that the resident was found to be dehydrated on examination with multiple wounds which were clean but had not been steri-stripped. He recommended hospital level care and reducing anti-psychotic medication and noted concern of the neglect in the care.

An unannounced inspection was undertaken by HealthCERT on the 10th March 2009. The inspection identified physical abuse occurring between residents and significant shortfalls in the standard of care consistent with the complaint[1]. There had been some changes in practice by the facility whereby prior evidence of inappropriate administration of prn (as needed) medicines was no longer evident and residents requiring dementia care had been moved from the rest home to the recently opened dementia unit. There was concern for two residents who may require a higher level of care and a referral has been made to the Needs Assessment Coordination Service. Matters of contractual compliance have been referred directly to the District Health Board.

[1] The investigation of neglect has been covered within other standards relating to the standard of care.

Further information was also requested from the manager in order to complete the inspection. This was subsequently received on the 25th March 2009.

Corrective actions

The following corrective actions are required:

1. To be compliant with Health and Disability Sector Standard 1.1.5 undertake actions to reduce the risk of abuse or neglect. This should include but is not limited to:
   - Ensuring that resident's have current needs assessments that verify their suitability for the level of service they are receiving
   - Ensuring staffing is sufficient to provide supervision of residents that have been identified as having challenging behaviour where aggression may be a feature
   - Ensuring staff are skilled in identifying triggers to challenging behaviour and managing challenging behaviour where they actively intervene to minimise risk to others.
2. To be compliant with Health and Disability Sector Standard 2.2.4 collect, analyse and evaluate quality improvement data that is regularly communicated to staff.

3. To be compliant with Health and Disability Sector Standards 2.2.5 document and undertake corrective action planning as part of the quality improvement process.

4. To be complaint with Health and Disability Sector Standard 2.3.1 document adverse, unplanned or untoward events in order to identify opportunities to improve service delivery and manage risk. In accordance with the stated facility policy that should include all skin tears and other incidents or accidents experienced by residents.

5. To be complaint with Health and Disability Sector Standards 2.3.2 ensure that incidents, accidents and other untoward events are analysed in a timely manner. This should include but is not limited to:
   - Trend analysis associated with individual residents
   - Trend analysis associated with the facility as a whole
   - Linking the analysis back to a quality improvement system

6. To be complaint with Health and Disability Sector Standard 2.4.1 ensure all complaints received irrespective of whether they are from staff, residents, relatives or others are actioned in accordance with the facility policy and comply with the Code of Health and Disability Consumers Rights for complaint management.

7. To be complaint with Health and Disability Sector Standard 2.4.5 link the complaint management process to the quality and risk management system.

8. To be complaint with Health and Disability Sector Standard 2.6.5 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.

9. To be compliant with Health and Disability Sector Standard 2.7.2 and 2.7.3 and 6.6.9 review current staffing allocations and practice to ensure:

- There is a registered nurse on all shifts, (not substituted by a "sleep over" registered nurse).
- Staff working in the dementia unit have appropriate qualifications and experience
- There are sufficient numbers of staff to reflect the acuity of resident need and minimum thresholds as set out in the facility protocol.

10. To be compliant with Health and Disability Sector Standard 4.1.1 and 6.6.2 ensure there are sufficient staff (at least one per shift) who hold current First Aid certificates.

11. To be compliant with Health and Disability Sector Standard 4.1.2 demonstrate involvement of family or the resident's representative (as appropriate) in all stages of service provision. This should include but is not limited to:
    - involvement in the development of lifestyle care plans
    - notification of incidents or accidents
    - notification of a change in condition of a resident (e.g. unexplained weight loss)

12. To be compliant with Health and Disability Sector Standard 4.1.4 document in sufficient detail assessments, planning, service delivery, evaluation and review for each resident that represents that resident's needs have been identified and services appropriately provided.

13. To be compliant with Health and Disability Sector Standard 4.1.5 ensure recordings are documented for residents accounting for:
    - appropriate assessment and treatment in the event of an untoward event (e.g. resident fall)
    - regular monitoring of the wellbeing of residents (e.g. monthly weights)

14. To be compliant with Health and Disability Sector Standard 4.2.2 ensure each resident's file will verify 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.

15. To be compliant with Health and Disability Sector Standard 4.3.1 the service will ensure that each resident's care plan is current.

16. To be compliant with Health and Disability Sector Standard 4.3.2 and 4.4.1 ensure care plans adequately reflect the interventions required to meet the assessed needs of residents and their associated goals.

17. To be compliant with Health and Disability Sector Standard 4.3.3 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.

18. To be compliant with Health and Disability Sector Standard 4.5.1 and 4.5.2 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.

19. To be compliant with Health and Disability Sector Standard 4.5.3 ensure that where progress is less than expected for a resident that this results in the formulation of a

short term care plan or revision of the life style plan where goals and interventions are developed against the assessed need. This includes but is not limited to:

- weight loss
- wounds
- infections
- challenging behaviour
- change in mobility
- change in continence
- change in hydration status

20. To be compliant with Health and Disability Sector Standard 4.6.1 provide an activities programme that contributes to the development and maintenance of interests that are meaningful to individual residents and meet their assessed needs.

21. To be compliant with Health and Disability Sector Standard 4.7.1 ensure the appropriate facilitation of referral to other services where this is indicated including referral to the Needs Assessment Coordination Service.

22. To be compliant with Health and Disability Sector Standard 5.3.1 ensure safe medication management practices are implemented within the service. This should include but is not limited to:
    - returning stock of controlled drugs of deceased residents to the pharmacy
    - storing temperature sensitive medications appropriately
    - keeping refrigerators clean and de-iced
    - keeping equipment used to crush medicines clean
    - ensuring medication profiles generated by the pharmacy are signed by the prescriber prior to being used

23. To be compliant with Health and Disability Sector Standard 5.6.1 implement effective infection control processes. This should include but not limited to:
    - Collection and analysis of infection data
    - Updating policies in accordance with the Infection Control Standard NZ8142
    - Implementing updated policies
    - Removing the sterilizer from the sluice room

24. To be compliant with Health and Disability Sector Standard 6.2.4 ensure the safety of consumers whereby continuous hot water systems have a guard or other mechanism to prevent the risk of burns to residents.

25. Provide a progress report that outlines Planned actions and actions taken to comply with the above corrective action requirements to HealthCERT before the 30th April 2009.

Additional Condition

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 North Waikato Care of Aged Trust Board Inc. - Kimihia.

1. A written progress report that outlines all actions undertaken by the Provider in relation to Corrective Actions 1, 4, 9, 10, 12, 13, 15, 16, 19, 21, 22, 23 & 24 (HDSS 1.1.5; 2.3.1; 2.7.2; 2.7.3; 4.1.1; 4.1.4; 4.1.5; 4.3.1; 4.3.2; 4.4.1; 4.5.3; .7.1; 5.3.1; 5.6.1; 6.2.4; 6.6.2 & 6.6.9) as identified in the Inspection Report must be submitted to the Director-General within one month of the issue of the amended schedule.

2. A written progress report that outlines all actions undertaken by the Provider in relation to Corrective Actions 2, 3, 5, 7, 8, 11, 14, 17, 18, &20 (HDSS 2.2.4; 2.2.5; 2.3.2; 2.4.5; 2.6.5; 4.1.2; 4.2.2; 4.3.3; 4.5.1; 4.5.2 & 4.6.1) as identified in the Inspection Report must be submitted to the Director-General within three months of the issue of the amended schedule.

3. A written progress report that outlines all actions undertaken by the Provider in relation to Corrective Action 6, (HDSS 2.4.1) as identified in the Inspection Report must be submitted to the Director-General within six months of the issue of the amended schedule.

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.

Background

Kimihia is certified under the Act for a period of 3 years, expiring on 19th February 2010. The re-certification audit undertaken by Telarc completed on the 22nd January 2007 found 3 criteria to be partially attained and 3 criteria to be unattained against HDSS, 10 partially attained and 2 unattained criteria against RMSP (excluding part 13) and 4 partially attained criteria against the Infection Control Standard.

A surveillance audit undertaken by Telarc on the 22nd July 2008 found all audited criteria to be fully attained.

Information held on file by the Ministry of Health includes the following complaints:

October 2004: Family allegation of lack of adequate care and abuse. HealthCERT required no further action as the matter was notified to the Health and Disability commissioner. There are no further notes on this matter recorded on the MOH data base.

HealthCERT received a complaint from Health consumer services (an advocacy service) on behalf of a power of attorney for a resident at Kimihia Rest Home on 11th February 2009, and following this further concerns were raised on 26th February by the Northland District Health Board.

The complaint relates to the care of a resident with dementia and alleges:

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The complaint is supported by a letter from a psycho-geriatrician to the general practitioner for this resident who noted concern that the resident had not been referred to mental health services for older people sooner or for fracture clinic appointments and that the resident was found to be dehydrated on examination with multiple wounds which were clean but had not been steri-stripped. He recommended hospital level care and reducing anti-psychotic medication and noted concern of the neglect in the care.

Kimihia recently opened (8 December 2008) a Dementia Unit with a capacity of 8 beds. This changed the configuration of beds reducing rest home beds by 8.

The following conditions of certification are required for all services certified under the Act:

The provider is required to advise the Director-General of Health, by written notification, of the provider's intention to increase the number of beds provided in the organisation, prior to these beds being used to accommodate consumers.

The Director-General of Health may impose any further condition, or vary any condition, where the Director-General of Health thinks it is necessary or desirable to do so in order to help achieve the purpose of the Act.

If requested in writing by the Director-General of Health, the provider must provide any information about the provision of the health or disability services specified in the request.

The provider is required to advise the Director-General immediately, by written notification, of any change to the manager (as defined in Health and Disability Sector Standard 2.1.3) of the organisation.

The provider is required to advise the Director-General of Health, by written notification, of the provider's intention to reconfigure the kinds of services being provided in any premises listed on its certificate. This includes:

- the addition of any kind of service that was not being provided at the premises at the time of the issue of the certificate;
- changes in bed capacity for the kinds of services being provided at the premises at the time of the issue of the certificate;
- the addition of any dedicated unit to meet the special needs of a consumer group, or changes to the bed capacity of the unit.

The provider must inform the Director-General of Health of any change of designated auditing agency, within one week of such a change occurring.

Service Description

North Waikato Care of Aged Trust Board Inc (Kimihia) provides Aged Residential Care Hospital and Resthome services in Huntly. The occupancy and capacity is outlined below:

Area	Occupied	Capacity
Hospital	19	22
Dementia	8	8
Rest Home	32	33
Total	**59**	**63**

Kimihia recently opened (8 December 2008) a Dementia Unit with a capacity of 8 beds. This changed the configuration of beds in the rest home by adding a "safe Care Unit" within it.

Reasons for the inspection

The purpose of the inspection was to determine whether health care services being provided by North Waikato Care of Aged Trust Board Inc (Kimihia), are being provided in compliance with section 9, Health and Disability Services (Safety) Act that is a person providing health care services of any king 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 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 complaint made to the Ministry of Health that may have resulted in systems failures and non-compliance against the Health and Disability Sector Standards. The scope of the inspection was widened as a result of issues noted on the tour of the facility.

Findings are according to the Health and Disability Sector Standards NZS8134:2001.

In obtaining evidence, HealthCERT officials have used professional judgement to assess the risk of material misstatement and designed further audit procedures to ensure that risk is reduced to an acceptably low level. A sampling methodology has been utilised. When designing the sample, objectives and attributes of the population from which the sample is drawn have been considered. This has included stratification of sub-populations by characteristic. Stratification of residents into hospital and rest-home classifications has assisted in the reduction in variability and therefore the ability to reduce the sample size and match compliance with relevant standards.

Methods for obtaining evidence included inspection, document and report review, observation, inquiry, confirmation and verification.

Means used for selecting items included:

- Selecting all items (100% examination). For example, medication charts, controlled drug registers, training/education plans and registers of attendance.
- Selecting specific items. For example, wound management assessments & plans, incident and accident reports, complaints register and supporting information, internal audits, policies and procedures.
- Audit sampling. For example care plans, clinical records, orientation programme for new staff, staff interviews.

Non-statistical sampling approaches (simple random sampling, systematic random sampling, convenience sampling, judgement sampling) have been used. Statistical sampling has not been applied in this investigation.

When considering sample results, HealthCERT officials have established whether an anomaly has arisen from an isolated event that has not recurred other than on specifically identifiable occasions or whether it is representative of similar anomalies in the population and is therefore indicative of a sub-optimal system or process arising to non-compliance with the Act. When an anomaly is found that has a common feature, for example wound management practices, the investigators have identified all items in the population which possess the common feature, i.e. residents requiring wound care and have then created a sub-population for analysis.

Where an isolated event has been identified, an anomalous error is considered to have occurred where the HealthCERT official has determined there is a high degree of certainty that such an anomaly is not representative of the population.

Practical limitations have also contributed to the chief determinant of sample size, for example time limitations.

Risk in relation to non-compliance has been assessed utilising the New Zealand Standards risk classification system. Attainment levels are assigned as either fully attained (FA), partially attained (PA) or unattained (UA).

The inspection was conducted utilising the following methods:

- Individual staff interviews – Individual staff interviews – 7 (manager, clinical manager - activities coordinator, care givers) staff were formally interviewed. An additional 6 staff members were informally interviewed during the course of the audit.
- Health Professional interviews – 1 General Practitioner with residents at the facility; 1 Physiotherapist who provides contracted services to the facility

- Needs Assessment and Coordination Service interviews – The manager and service coordinator who undertakes service coordination for residents at the facility
- Relative interviews – 3 relatives were formally interviewed.
- Residents- Several residents were informally greeted and general conversations undertaken.
- Observation: During facility tours and casual observation of the facility
- Document review: See the appendix for a list of documents that were requested as part of the audit process.
- Clinical Notes review: A sample of 6 subsidised residents' notes from the facility was audited.

This inspection did not constitute a full audit against the Health and Disability Sector Standards, Infection Control Standard or Restraint Minimisation and Safe Practice Standard.

Limitations

The Health and Disability Services (Safety) Act, requires that A person providing health care services of any kind must do so while meeting all relevant service standards.

Section 40 delegations enable HealthCERT to:

- Enter and inspect
- Take possession of any equipment / device
- Inspect any document
- Take or make copies

Section 43 Authorised person may require any person appearing to be in charge of, employed in or undertaking or recently having undertaken any work to answer any questions about:

- Health and safety of consumers
- Persons are not required to answer questions if the answer may tend to incriminate him or her.

However it is an offence under section 54(2) to

- intentionally obstruct, hinder or resist and authorised person exercising or attempting to exercise powers under the act; or
- intentionally fails to answer a question (other than a question whose answer may tend to incriminate the person); or
- when asked a question by an authorised person, gives an answer the person knows to be false or misleading

Opening meeting

On arrival at 8.30 am the manager was not present. The receptionist phoned the manager and the unannounced inspection letter was read to the manager by XXX XXX. The manager directed XXX to commence the audit with the assistance of the clinical nurse manager, XXX XXX.

An opening meeting was attended by XXX XXX, XXX-XXX XXX and XXX XXX. The meeting commenced at 9.45 am and concluded at 10.00 am. The introduction meeting covered the following points:

Explanation of purpose of visit Section 40 (1) (b) **To determine whether health care services being provided by North Waikato Care of Aged Trust Board Inc (Kimihia) are being provided in compliance with section 9 Health and Disability Services (Safety) Act,** that is **A person providing health care services of any kind must do so while meeting all relevant service standards.**

Delegations section 40:

- Enter and inspect
- Take possession of any equipment / device
- Inspect any document
- Take or make copies
- Section 43 Authorised person may require any person appearing to be in charge of, employed in or undertaking or recently having undertaken any work to answer any questions about:
- Health and safety of consumers
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- However it is an offence under section 54 (2) to
    - intentionally obstruct, hinder or resist and authorised person exercising or attempting to exercise powers under the act; or
    - intentionally fails to answer a question (other than a question whose answer may tend to incriminate the person); or
    - when asked a question by an authorised person, gives an answer the person knows to be false or misleading.

A proposed agenda for the day was discussed 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.

Summary of inspection findings

Summary of findings where non-compliance to the Health and Disability Sector Standards has been identified specific to the complaint and inspection. As previously noted, the scope of the inspection was widened in response to the tour of the facility and interviews with staff.

Consumer Rights during Service Delivery - Standard 1.1

1.1.5 – Partial attainment – High Risk

There was documented evidence of the resident subject to the complaint having been assaulted by another resident. There were at least two other examples where residents have been assaulted by other residents including a recent incident on the 8th March 2009.

There had not been staff training that addresses abuse and neglect issues provided to staff in the 2008 in-service training programme.

Quality and Risk Management Systems - Standard 2.2

2.2.4; 2.2.5– Partial attainment – Moderate Risk

There was not a complete record of incidents and accidents held for the resident subject to the complaint. 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.

The manager was unable to provide a documented example of analysis and quality improvement initiatives. There was no quality meeting minutes available to the auditors. Staff report that there have not been quality meetings or components of staff meetings specific to quality improvement. It was noted that some information on infection trends are relayed to staff.

There was no evidence of internal audits to monitor compliance with the standards encompassing a corrective action plan and evaluation of the action leading to an outcome.

Exception Reporting - Standard 2.3

2.3.1; 2.3.2 – Partial attainment – Moderate Risk

Staff stated that they do not always complete an incident or accident record. For example, where a skin tear occurs this may be noted in the progress notes but information may not be recorded elsewhere. There were multiple examples of wound care assessment plans documenting incidents (skin tears and a burn) that did not have associated incident, accident or injury forms completed.

Once an accident/injury form is completed by a staff member, the clinical manager completes a risk assessment section that includes whether an investigation has been carried out, whether a significant hazard was involved and signs this.

This is an incident and near miss form used by the facility. A completed example does not provide for the manager to make a comment.

There was no evidence of other forms being used to develop corrective actions associated with incidents or accidents.

There was no evidence of investigation; analysis; identification of trends; Planned corrective action or review process provided to the auditors. It was stated by the manager that information is entered into a data base that can then be used to undertake analysis. When an example was requested, a long print out was produced. There was no associated analysis or link to the quality management system.

Complaints Management - Standard 2.4

2.4.1 – Partial attainment – Low Risk

There was no evidence of a system to ensure all complaints were entered; monitored for trends and improvement to service delivery applied.

The complaints folder reviewed included several complaints from staff and one complaint from an agency nurse. There were no other complaints in the complaints folder. The complaint relating to the resident whom prompted this audit was held separately by the manager as the file was in the process of being actioned.

In relation to the current resident complaint, the manager had sent an email to the advocate to the complaint suggesting that a meeting be held to discuss the issues raised. The complaint letter was dated 10th February and the email was dated 24th February. The manager had not received a response back from the email. The complaints procedure states that "the complainant is to be advised within 7 working days that the complaint has been received"

Human Resource Management - Standard 2.6

2.6.5 – Partial attainment – Moderate Risk

An in-service training plan has not been developed for the 2009 calendar year. Records for the 2008 calendar year indicated an attendance rate of less than 50 % of care staff with the exception of the Fire Drill.

Service Provider Availability - Standard 2.7

2.7.2; 2.7.3; 6.6.9 – Partial attainment – High Risk

The manager reports that she staffs over the level indicated through the Access Data base programme.

The formula used by the facility (outdated Midland Regional Health Authority) requires 1.95 caregivers per day in the rest home, 2.79 in the dementia unit and 2.75 in the hospital. A review of rosters across 12 weeks found that these thresholds were not met.

A room has been permanently set up for registered nurses to "sleep over" as this is a common practise due to unavailability of registered nurse coverage on night shift. A review of rosters for the past 12 weeks found that the percentage of sleepovers by Registered Nurses varied from 5 % - 48 % per week.

The allocation of staff to the dementia unit is one care giver per shift for 8 residents.

Service Provision Requirements - Standard 4.1

4.1.1[2] – Partial attainment – High Risk

Staff interviewed said they did not hold First Aid certificates. The clinical manager stated that due to the expense First Aid certificates sponsoring these costs for staff did not occur. Documentation associated with accident or injury of residents did not always include a description of the first aid measures taken.

It was stated that staff working in the Dementia Unit held qualifications specific to dementia care. A review of the roster did not always reflect this.

4.1.2 – Partial attainment – Low Risk

There was no evidence of family involvement in care planning. Relatives interviewed indicated they were contacted in the event of illness, incident or accidents. This is supported by progress notes that indicate family members are contacted in the event of an incident. There is no provision to record this information on the incident or accident/injury form.

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[2] Cross references to 2.7.3 and 6.6.2

4.1.4; 4.1.5 – Partial attainment – High Risk

No evidence was found regarding assessment for pain management, fall management or pressure /skin integrity risk assessment or management.

Where a resident had clearly had a change in continence status since admission, there was no continence assessment. The only documentation found was that the resident requires a No. 8 product day and night which was written under toileting in the care plan.

There was no evidence of documented and current short term care planning.

Wound care planning is incomplete and does not represent a thorough wound assessment or planning process.

Where residents had sustained falls there was not recording of vital signs or documentation of an assessment.

There is not monthly monitoring of weights of all residents.

Where a resident had a change in behaviour and infection was suspected there was no evidence of temperature recording or urine testing.

There is not use of short term care plans. Lifestyle care plan for each resident are brief.

The Clinical Manager reported that documentation is not a priority as there is insufficient time available to her to undertake her duties.

Assessment - Standard 4.2

4.2.2 – Partial attainment – Moderate Risk

Goals are not recorded within the currently used nursing care assessment with Nursing care plan (an amalgamated document that has been developed by the facility).

Planning - Standard 4.3

4.3.1; 4.3.2[3] – Partial attainment – High Risk

The nursing care plan for the resident subject to the complaint was incomplete. There were sections of the care plan that were left blank (mobility, showering, dressing, grooming, feeding, cultural).

There were was no indication of mobility needs or interventions on the care plan despite evidence of Mrs X frequently falling.

There was no indication on the care plan that the resident suffers from confusion or other behavioural symptoms (a letter written by a specialist physician noted advanced dementia with neuropsychiatric manifestations of aggression, both verbal and physical, calling out, behaviour and wandering). In the section of the care plan under 'psycho' the following information was written 'lofty monkey to cuddle', reassurance, behaviour due to reduced sight and hearing. Refuses to take her pills at times.

[3] Cross references to 4.4.1

There was no indication of the frailty of her skin and frequent skin tears. There was no interventions noted that would assist in maintaining skin integrity.

This care plan was signed as having been last updated on the 14th January 2009. A prior care plan dated 10th November 2007 which the auditors were advised was not current included goals to maintain mobility, assist with activities of daily living, maintain a calm and reassuring environment to reduce aggressive outbursts and to maintain skin integrity. This care plan template provides the equivalent of initial assessment information and notes an increased risk of falls and history of dementia where the resident requires assistance with all activities of daily living.

A review of other care plans indicated they were also incomplete and out of date. For example residents in the dementia unit did not have interventions to describe how to manage challenging behaviour. For a resident who had attacked another resident, the progress notes record that the resident had been restless all morning prior to the incident. There interventions listed to manage his challenging behaviour was 'take time to talk to him – alleviate anxieties and fear, reassurance, good family input" Another resident noted in progress notes and incident and accident reports as frequently falling did not have any strategies in the care plan or assessment by the contracted physiotherapist.

4.3.3 – Partial attainment – Low Risk

Care plans and progress notes were kept separately to the remainder of the file. Incident and accident files were not retained within the clinical file in all instances.

Evaluation - Standard 4.5

4.5.1; 4.5.2 – Partial attainment – Moderate Risk

Where the care plan for the resident subject to the complaint had been updated three times, there was no evidence of a documented evaluation against the goals and interventions.

Through documentation of accidents, wound plans and progress notes it is apparent that the resident subject to the complaint has experienced a change in her condition over time that is not reflected in the evaluation against goals.

A review of a selection of current care plans found that goals were not set for residents.

Unexplained weight loss in more than one resident had not been noted as a problem or action taken to further assess or treat. There were three examples of significant unexplained weight loss (e.g. weight loss of 8kg over 2 months) where no actions had been taken to further assess or remedy.

4.5.3 – Partial attainment – High Risk

There was no use of short term care plans in current files. There was some evidence of limited use of short term care plans in archived records.

There was no evidence of care plans being updated to reflect a change in need.

Progress notes have a column for plan and treatment. The clinical manager reported that this area is used instead of short term care plans. There was one example where this

column had been used to record a temperature and blood pressure. This did not correspond with the care plan or narrative in the progress notes.

Planned Activities - Standard 4.6

4.6.1 – Partial attainment –Moderate Risk

There is half an hour per day five days per week for diversional therapy activities in each area (rest home, hospital and dementia unit).

The person undertaking this role does not hold or is studying towards a qualification in diversional therapy but does hold a national certificate in care giving. Services do not have the appropriate service provider skill mix to undertake the activities. (One care giver staff member finds it hard to balance activities across all three areas)

There was no evidence of resident input into the development of the activities plan or resident /family feedback to demonstrate the programme meets needs and is meaningful. No evaluation/review process was in place to ensure the programme reflects standards and achieves its objectives.

Activities in the dementia unit include newspaper reading, Craft, Dance, Ball, Bowls.

Individual planning and delivery of one-to-one activities is limited.

Referral to Other Health and Disability Services (Internal & External) - Standard 4.7

4.7.1 – Partial attainment – High Risk

Referral had not been made to the Needs Assessment Coordination Service (NASC) for two residents that were made known to the auditors that have had a change in needs. This includes the resident that had attacked the resident subject to the complaint.

Clinical files reviewed for the resident subject to the complaint indicate that she was not referred for specialist services where it was clinically indicated to do so.

Medicine Management - Standard 5.3

5.3.1[4] – Partial attainment – High Risk

Controlled drugs of deceased residents dating back six months had not been returned to pharmacy, and were being held for future use if required outside pharmacy hours.

Medications sensitive to temperature increases i.e. Nilstat (<25C) were not stored correctly.

The medication refrigerator was found to be iced up and there was no daily monitoring of the temperature.

[4] Note that a review of medication profiles for every resident in the hospital and every resident in the dementia unit did not indicate inappropriate use of prn medications over the last two months.

Intravenous fluids were found to be out of date.

The pestle used for crushing medications was not cleaned between residents' thus aiding a contamination of medications provided to the residents.

There was use of a medication profile for a resident that had not been signed by the medical practitioner. This profile differed from the previously signed profile that had not been altered to amend or stop medications.

Flucloxacillin 250 mg tds was written on the medication profile and was not signed and did not indicate a start or stop date (an 8 day course was given).

Infection Control Management - Standard 5.6

5.6.1 – Partial attainment – High Risk

There was minimal collection of infection control data and analysis, The Infection Control Policy was dated 2005 and had not been revised, there was no policy for managing outbreaks.

Urine testing strips in the sluice rooms were out of date.

Staff hand basins and resident bathroom and toilet hand basins were found to have cracked cakes of soap in use. There was minimal use of hand sanitizers.

Waste bins in sluice rooms were not foot peddled and required to be hand raised and closed.

Face guards were evidenced in the sluice rooms but not evidenced being used by staff.

The sterilizer for instruments was stored and used in a sluice room, where instruments were being packed and sterilized.

Clean and dirty linen was stored on the same trolleys and trolleys with clean linen in halls were not covered.

Mops used for cleaning were very discoloured and although the manager stated that these were changed daily there was not evidence of spare mop heads in the cupboards.

There was evidence of a large number of flies within the facility. It was confirmed by the manager that insect control spray was used outside the facility yearly.

It was noted that kitchen windows were open and that fly screens on the windows were in poor condition with large gaps in some, allowing access by flies. Overhead fans in use in the kitchen were visibly dirty.

Facility Specifications - Standard 6.3

6.2.4 – Partial attainment – Moderate Risk

Continuous Hot Water Systems were present in resident areas and did not have a guard or other mechanism to reduce risk of hot water scalding.

Summation meeting

A brief summation meeting attended by XXX XXX, XXX XXX, XXX-XXX XXX and XXX XXX. XXX thanked XXX and her staff for their cooperation during the audit process and noted that more information was needed to complete the audit. Once further information was collected the Ministry of Health would be in a position to issue an audit report that would include specific findings against the Health and Disability Sector Standards.

XXX noted that relatives interviewed on had been complementary to the service.

The alleged complaint would be upheld in relation to:

- Physical abuse between residents
- Lack of appropriate first aid and follow-up care following injury
- Insufficient falls management
- Unexplained weight loss
- Neglect in providing care of an adequate standard

Current administration of medicines could not confirm the inappropriate administration of prn medicines.

Further information and consideration of information photocopied would be required before a determination could be made in respect to:

- Inappropriate ongoing placement of a resident in dementia care when hospital level care was required
- Over charging the DHB for hospital level care when rest home care was being provided

XXX confirmed that there would be findings against the following areas:

- Assessment
- Care Planning
- Short Term Care Planning
- Activities Programmes/Diversional Therapy
- Evaluation
- Infection Control
- Medicine Management
- Abuse between residents
- Acute care management – including lack of First Aid Training
- Referral to other services
- Weight loss
- Quality and risk management systems
- Incident and Accident Management
- Integration of records

Any further requests for information would be made directly to XXX by XXX-XXX.

XXX invited comment from XXX and XXX. There were no specific queries raised and XXX may the comment that she felt overwhelmed by the likelihood of the number or extent of findings.

The meeting commenced at 2.55 pm and concluded at 3.10 pm.

Conclusion

The inspection of North Waikato Care of Aged Trust Board Inc (Kimihia) identified physical abuse occurring between residents and significant shortfalls in the standard of care consistent with the complaint. There had been some changes in practice by the facility whereby prior evidence of inappropriate administration of prn (as needed) medicines was no longer evident and residents requiring dementia care had been moved from the rest home to the recently opened dementia unit. There was concern for two residents who may require a higher level of care and a referral has been made to the Needs Assessment Coordination Service. Matters of contractual compliance have been referred directly to the District Health Board.

North Waikato Care of Aged Trust Board Inc (Kimihia) will be required to take corrective actions to improve compliance against the Health and Disability Sector Standards. On-going monitoring will be undertaken by the Ministry of Health in conjunction with the District Health Board.

Report

A copy of HealthCERT's report is to be sent to the Waikato District Health Board and the Health and Disability Commissioner.

Appendix

Documents requested

- Staffing and skill mix policy (not available on the day of inspection, provided subsequent to the inspection)
- Management of challenging behaviour policy
- Assessment and care planning policy
- Entry to services policy
- Referral to other services policy
- Complaints management policy
- Reassessment of residents policy (by NASC)
- Staff orientation policy and process
- Complaints file
- Quality and risk management plan
- Incident and accidents register/file
- Restraint register
- Informed consent policy and procedure
- Rosters (last 12 weeks and forward rosters)
- Staff training records and in-service training programme (not available on the day of inspection, provided subsequent to the inspection)
- Minutes of staff meetings (not available)
- Minutes of quality meetings (not available)
- Assessment tools
- Resident files
- Completed resident satisfaction survey (not available)
- Residents weights
- Menu's