Inspection Report

Wattledowns Holdings Limited
Wanganui

10 March 2009

HealthCERT
Quality & Safety
Sector Accountability and Funding
Ministry of Health

Contents

Undertaken 24th February 2009
File Ref: WWA28
Provider: Wattledowns Holdings Limited
Contact Person: XXX XXX, Owner
Premise: 35 Treadwell Street, Springvale, Wanganui

Executive summary

HealthCERT was advised by the Health and Disability Commissioner of a number of concerns about the standard of dementia care at Wattledowns Holdings Limited, Wanganui, raised by three resident family members and XXX.

The Health and Disability Commissioner notified Wattledowns Holdings on 27 November 2008 of the complaints and that due to the number of issues involved and the number of complaints that had been brought to his attention that the matter had been referred to the Director-General of Health pursuant to section 34(1)(c) of the Health and Disability Commissioner Act 1994.

The Ministry of Health contacted Whanganui District Health Board and agreed that the District Health Board would undertake an inspection to identify any immediate concerns regarding resident safety at the facility and that the Ministry of Health would undertake an unannounced inspection in the New Year. The District Health Board visited the facility and notified the Ministry of Health that there were no immediate concerns for resident safety.

Wattledowns Holdings Limited independently provided information to the Ministry of Health of an internal investigation and associated corrective actions undertaken as a result of notification of the complaints received by the Health and Disability Commissioner. This investigation verified a number of the concerns raised by the complainants.

An unannounced inspection was undertaken by HealthCERT on 24 February 2009. The inspection identified:

- Quality and risk management systems could not be demonstrated with the loss or non-completion of incident and accident reporting and corrective action planning for the 2008 calendar year.
- Provisions under the Aged Residential Care Agreement with the District Health Board were in breach with respect to on-charging a subsidised resident's relative for wound care products and general practitioner visits.
- A current record of education and training for each staff member and the proposed in-service training plan for 2009 was not available at the time of inspection.
- Staff allocation practices did not provide an assurance that staff are assigned to the care of every resident on every duty.
- There is not a registered nurse on-call and available to the facility where a registered nurse is not present on duty at the facility.
- A current needs assessment could not be located for every resident.

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- There was limited demonstration of family involvement in care planning and service delivery.
- Clinical records including assessments, care planning and progress reporting were not always completed in sufficient detail to demonstrate the needs of residents had been met.
- Assessments had not been undertaken or were not current for those residents with challenging behaviour, weight loss or incontinence.
- Lifestyle plans were not always current and did not reflect the level of interventions required.
- Short term care plans, where used, required revision in order to reflect the current needs of residents.
- Evaluation of lifestyle plans and short term care plans was not always evident.
- The planned activities programme was insufficient to meet the needs of dementia residents in maintaining and developing meaningful interests.
- There was little evidence of individual planning and implementation of individual activities for residents.
- Clinical records were not integrated.
- The medicine management system was found to be unsafe.
- There was not regular temperature testing at the point of food service.
- Several laundry practices were not consistent with current accepted infection control practices.
- Shared rooms did not provide for adequate visual privacy.
- There was a bolt to one resident door.

An immediate requirement was made to implement safe medicine management practices, which was further followed up with a requirement letter. There was also agreement from the facility manager to remove the bolt from the resident door and to ensure staffing allocation included staff having responsibility for individual residents.

Further information was also requested from the facility manager in order to complete the inspection. This was subsequently received on 6 March 2009 and 10 March 2009.

Corrective actions

The following corrective actions are required:

1. To be compliant with Health and Disability Sector Standard 2.2.5 undertake corrective action planning to address areas identified as requiring improvement that has arisen from incident/accident analysis, complaints analysis and other quality monitoring activities. Ensure there is a mechanism to evaluate the effectiveness of actions taken.

2. To be compliant with Health and Disability Sector Standard 2.3.1 document adverse, unplanned or untoward events (incidents and accidents) including service shortfalls in order to identify opportunities to improve service delivery and to identify and manage risk.

3. To be compliant with Health and Disability Sector Standards 2.3.2 ensure the exception reporting system (incidents, accident and complaints) is planned and coordinated and links to the quality and risk management system.

4. To be compliant with Health and Disability Sector Standard 2.5.1 review all invoicing made to residents (or their relatives) who receive a government subsidy for their care to ensure that contractual obligations are met. Make any refunds that may be due.

5. To be compliant with Health and Disability Sector Standards 2.7.2 ensure the staff skill mix and rostering policy is implemented whereby staff are assigned to care for specific residents on each shift.

6. To be compliant with Health and Disability Sector Standard 2.7.3 ensure that an experienced registered nurse is available to the facility in an on-call capacity where a registered nurse is not present on duty.

7. To be compliant with Health and Disability Sector Standard 3.1.3 ensure entry to services is linked to an assessment process consistent with the provision of dementia level care.

8. To be compliant with Health and Disability Sector Standard 4.1.2 develop care in partnership with families as appropriate and ensure communication to families of incidents of accidents involving their family member.

9. To be compliant with Health and Disability Sector Standard 4.1.4 ensure records are current and recorded in sufficient detail to identify needs and demonstrate that needs have been met.

10. To be compliant with Health and Disability Sector Standard 4.2.2 undertake re-assessments or assessments for each resident with challenging behaviour, incontinence, falls or weight loss and use this information to inform service delivery planning.

11. To be compliant with Health and Disability Sector Standard 4.3.3 update lifestyle care plans describing the support interventions required to achieve each resident's goals identified from the assessment process.

12. To be compliant with Health and Disability Sector Standard 4.4.1 update short term care plans to ensure interventions are consistent with meeting short term needs.

13. To be compliant with Health and Disability Sector Standard 4.5.2 document the evaluation of lifestyle plans where needs of residents have changed or where evaluation is due in accordance with contractual requirements for subsidised residents.

14. To be compliant with Health and Disability Sector Standard 4.6.1 and 4.6.2 review the current group and individual activities programmes considering the needs of dementia residents whom may require an advanced activities programme across a 7 day week.

15. To be compliant with Health and Disability Sector Standard 5.2.5 integrate clinical records pertaining to individual residents.

16. To be compliant with Health and Disability Sector Standard 5.3.1 implement a system to manage the safe and appropriate prescribing, dispensing, administration, review, storage and disposal of medicines occurs in order to comply with legislation, regulations and guidelines.

17. To be compliant with Health and Disability Sector Standard 5.4.4 undertake regular temperature testing of food at the point of food service in order to comply with guidelines for food preparation and serving.

18. To be compliant with Health and Disability Sector Standard 5.5.2 implement a process for monitoring the effectiveness of methods, frequency and materials used for cleaning and laundry processes.

19. To be compliant with Health and Disability Sector Standard 5.6.1 ensure effective infection control is achieved through implementation of policies and procedures in laundry services and medication management.

20. To be compliant with Health and Disability Sector Standard 6.1.1 ensure all shared rooms provide for adequate visual privacy.

21. To be compliant with Health and Disability Sector Standard 6.2.3 remove the bolt from the resident room door.

Additional Condition/s 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.

Conditions

The following conditions will apply to the Provider's current schedule to provide rest home health care:

- A written progress report that outlines all actions undertaken by the Provider in relation to Corrective Actions 1 – 21 (HDSS 2.2.5, 2.3.1, 2.3.2, 2.5.1, 2.7.2, 2.7.3, 3.1.3, 4.1.2, 4.1.4, 4.2.2, 4.3.3, 4.4.1, 4.5.2, 4.6.1, 4.6.2, 5.2.5, 5.3.1, 5.4.4, 5.5.2, 5.6.1, 6.1.1 and 6.2.3) as identified in the Inspection Report must be submitted to the Director-General within two months of the issue of the amended schedule.

- 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 purpose of the Act.

Background

Wattledowns Holdings Limited is certified under the Act for a period of three years, expiring on 14 December 2009. A surveillance audit undertaken by a designated audit agency on 15 May 2008 found all criteria to be fully attained against Health and Disability Sector Standards, Restraint Minimisation and Safe Practice and Infection Control Standards with multiple continuous improvements awarded by the auditors, BVQI.

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

Wattledowns Holdings Limited is a 33 bed dementia unit (rest home level care).

Reasons for the inspection

As a result of the Health and Disability Commission complaint notified to the Ministry of Health in November 2008, the Ministry of Health notified the Health and Disability Commissioner of their intent to undertake an unannounced inspection in early 2009. The nature of the inspection is to investigate the following concerns raised in the complaint to the Health and Disability Commissioner:

- Competence of the manager
- High staff turnover impacting on skill sets and competence of staff
- Inadequate staffing levels
- Inadequate management of personal items and resident clothing
- Unacceptable standards of care (personal hygiene, management of challenging behaviour, activities and exercise)
- Lack of personalisation of rooms
- Lack of cleanliness of the facility
- Lack of involvement of family in care planning including communication of incidents and accidents to family
- Insufficient care giver training
- Inadequate behavioural assessment of residents
- Poor complaints management
- Inadequate management of continence
- Weight loss of residents
- Lack of personal privacy for residents

- Infection control issues

The purpose of the inspection was to determine whether health care services being provided by Wattledowns Holdings Limited, 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 XXX XXX, Team Leader HealthCERT and XXX XXX, Senior Advisor HealthCERT under the delegated authority of the Director-General of Health.

Methodology

The inspection was conducted to investigate the complaints made to the Health and Disability Commissioner 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 – 9 (manager, 1 registered nurse, 3 healthcare assistants, 1 trainee diversional therapist, 1 cook, 1 laundry staff, 1 cleaner) staff were formally interviewed. An additional 2 staff members were informally interviewed (including the nurse educator who works on contract) during the course of the audit.
- Relative interviews – 3 relatives were interviewed.
- The DHB Specialist Wound care nurse was formally interviewed
- Telephone interview with the DHB to confirm subsidy status of a resident
- Residents - Several residents were informally greeted and general conversations undertaken.
- Observation - During facility tours and casual observation of Rest Home and Dementia Unit.
- Document review - See the appendix for a list of documents that were audited as part of the audit process.

- Clinical Notes review: A sample of 9 subsidised residents' notes was audited and a sample of 28 resident weight records.

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 9.30 am, the manager was not present at the facility. A staff member on duty was able to contact the manager who returned to the facility. The auditors waited in the resident lounge until the manager arrived. A letter of notification of an unannounced visit was provided to XXX XXX, Manager by XXX XXX at 9.45 am.

An opening meeting was attended by XXX XXX, Manager and XXX XXX, Registered Nurse, 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 Wattledowns Holdings Limited 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.

An outline of the day was discussed and included a request to interview staff (including the diversional therapist) and any relatives or health professionals that might be visiting.

Summary of Inspection findings

Personal Privacy and Dignity - Standard 1.7

1.7.1: Fully Attained
The manager and staff report that 80-90% of resident clothing is labelled. Staff report that there is not a communal pool of clothing but that residents do at times take other resident's clothing and wear it. Attempts are made to return the clothing to the owner when this occurs. Clothing viewed in the laundry was labelled.

Governance - Standard 2.1

2.1.3: Fully Attained
The recently appointed manager has prior experience of two years working in a management position at Idea Services. The manager has completed the ACE Core Programme, Health Ed On-site assessors course, the Centre for Leaning Supporting an Older Person who is affected by Dementia and a range of other short clinically orientated courses for the non-regulated workforce. Management training has been limited to in-service training that had been provided directly by her previous employer.

The registered nurse holds a current annual practising certificate and has attended a range of courses supporting her professional development. Her portfolio was not available to view on the day of the audit. The Ministry of Health received further information on the 6th March 2009 indicating the registered nurse regularly participates in professional development activities relevant to care of older people.

Quality and Risk Management Systems – Standard 2.2

2.2.4: Fully Attained
It was reported by the manager that quality improvement data has been collected and analysed by month. Data and associated analysis for the 2008 calendar year could not be located. Data for January 2009 had been collated and February data partially collated.

Correspondence received by the Ministry of Health dated 2nd March 2009:

- Accident summary form completed for April 2008 – January 2009
- Accident /Incident analysis summaries for 2008 calendar year and Jan/Feb 2009

Note: Refer also to 2.3.1 impact on the accuracy of reporting.

2.2.5: Partial Attainment: Moderate Risk
There were no corrective action plans available to view other than the corrective action plan developed in relation to the complaints received by the Health and Disability Commissioner. Staff interviewed reported that they had not been directly involved in quality improvement initiatives arising from analysis of incident or accident reports or complaints.

Summaries from the Incident and Accident analysis indicates corrective actions completed and in some instances records what this action has been but does not provide any follow-up of the effectiveness of these actions.

Exception Reporting – Standard 2.3

2.3.1: Partial Attainment: Moderate Risk
Incident and accident reports for the last year were not evident in resident files or in the incident and accident reporting folder. In one resident file progress note reporting in October 2008 indicates that the resident had sustained an accident and an incident form had been completed. There was not an incident/accident record in her clinical file to support this. Staff were unable to locate the specific incident/accident record referred to. There was more than one instance where this was demonstrated in clinical files reviewed.

2.3.2: Partial Attainment: Moderate Risk
Linkages between incident and accident reporting and quality management systems could not be demonstrated as there was no documentation available to review.

Complaints Management - Standard 2.4

2.4.1: Fully Attained
There had not been any reported complaints since appointment of the new manager. The manager was able to explain the complaint management process as were staff interviewed.

2.4.2: Fully Attained
Information about the facility including the complaints management process is provided to residents and relatives upon admission. There is a system for complaints and complements.

2.4.4: Fully Attained
The complaints management policy and manager explanation of the process support achievement of this criterion.

2.4.5: Fully Attained
Policies and procedures support achievement of this standard not withstanding there have not been any complaints since November 2008.

Service Management – Standard 2.5

2.5.1: Partial Attainment: Moderate Risk
A subsidised resident had been charged for wound care products, scheduled and emergency general practitioner visits (approximately $2000 over three months). This is inconsistent with the Aged Residential Care agreement with the District Health Board.

Human Resource management - Standard 2.6

2.6.4: Fully Attained
Staff interviewed who had been appointed over the last 12 months reported having received a brief orientation period that included competence testing to administer medications and a check list to complete over the first three months in employment. More recently appointed staff interviewed reported having received a period of buddying before being given a full workload.

Policies, procedures and checklists were present for the orientation of new staff.

2.6.5: Fully Attained
There is a staff educator who is responsible for the delivery of an in-service training programme and facilitation of Career Force training programmes.

The 2008 training programme was viewed and included a range of topics (delivered as short 1 or 2 hour training sessions). Most sessions were delivered by the staff educator.

Staff report that they attend the majority of in-service training sessions. (Attendance ranged from 50-80% in records reviewed).

The training programme for 2009 was not available to view on the day of audit. The 2009 programme schedule was received by the Ministry of Health on the 6th March 2009 and includes a monthly in-service training. Additional information was provided on extra education available in the community in 2009 that staff may be attending. An updated list of those staff who hold core and dementia specific care giving certificates was also not available. The Ministry of Health received a staff record of training dated 1st March 2009 which indicated 8/15 staff working with residents had completed formal care giving training including Unit Standard 17029 (Dementia) and that 6 staff would be commencing this standard equivalent in March 2009. 2 staff who did not hold any certifications in care giving are starting stage 1 in March 2009.

Service Provider Availability – Standard 2.7

2.7.1: Fully Attained
The manager has reviewed the staffing levels and allocation of staff across the facility and as a result has increased the number of care giving staff and altered duties of staff to include specific duties for those undertaking laundry and kitchen duties.

There is a senior care giver rostered to the facility for each duty. There is an allocation process that includes staff being allocated specific residents to care for.

2.7.2: Partial Attainment: High Risk
Staff interviewed reported that they work on a team basis whereby they do not take responsibility for specific residents. There is an informal arrangement where the person that 'gets the resident up, is responsible for writing their progress notes'. It was acknowledged that if a resident is an early riser and is up at the start of a morning duty that there may not be a care giver who takes specific responsibility for that person. The process is less clear in the afternoon as there is a floating person who may or may not take responsibility for a specific resident.

2.7.3: Partial Attainment: Moderate Risk
There is not always a registered nurse on call for the facility when the registered nurse is not on duty. Staff report that a senior care giver often fulfils this role.

Pre-entry and Entry to Services – Standard 3.1

3.1.3: Partial Attainment: Moderate Risk
There were not needs assessments (completed by the NASC or Provider Arm) present in each resident's file (either in the current clinical file or recently archived file).

Service Provision Requirements – Standard 4.1

4.1.1: Partial Attainment: Low Risk
Records provided for the 2008 year indicate that there are sufficiently trained and qualified staff to provide services.

4.1.2: Partial Attainment: Low Risk
Relatives interviewed had not been provided with the opportunity to comment on or have input into the lifestyle care plans.

In clinical files reviewed there was limited evidence of family involvement.
In recent incident and accident records reviewed family were not always contacted in the event of an incident or accident.

Relatives interviewed stated that they had mostly been contacted when there was a change in the condition of their family member.

4.1.4: Partial Attainment: Moderate Risk

Life style care plans were not current for 8 of 9 files reviewed.
Assessments to support care planning and service delivery were not current in 3 of 5 files reviewed. Assessments were also not present where it was indicated an assessment should have been completed. For example a resident receiving continence products had not had a continence assessment undertaken; a resident with challenging behaviour had not had a behavioural assessment or the establishment of a behavioural log.

There was insufficient documentation in progress notes in the absence of incident/accident reporting to demonstrate that the needs of a consumer had been met after suffering from an injury.

Assessment – Standard 4.2

4.2.2: Partial Attainment: Moderate Risk
In 5 of 9 clinical files reviewed, insufficient or out-dated assessment information was present.

There is predominant use of a brief checklist for determining resident continence needs that is not consistent with current accepted practice.
There was not a documented behavioural assessment that supported the development of goals and interventions recorded in the clinical record of a resident whom had been identified as having challenging behaviour.

In records reviewed there had not been regular monitoring of resident's weights. In a wider sample of weight records, there was variable reporting and monitoring of resident weights. Where regular monitoring was found in three files, weight loss had not been investigated or an action plan put in place to counter the weight loss.

Staff interviewed reported that many lifestyle plans were out of date and did not reflect the current needs of residents.

Planning – Standard 4.3

4.3.2: Partial Attainment: Moderate Risk
8 of 9 Life style care plans reviewed were not current including interventions that were no longer relevant.

For example a resident who is now using a walking frame to mobilise recorded that she was fully mobile. Another resident who was incontinent recorded that she was continent.

Service Delivery/Interventions – Standard 4.4

Refer also 4.3.2
4.4.1: Partial Attainment: Moderate Risk
There was evidence of short term care planning. In two instances where short term care plans were reviewed these had not been updated to close out or amend the interventions required for the short term requirements. For example a resident no longer had an ear infection so did not require the interventions as stated.

The DHB wound care nurse specialist is used to assist in the assessment and management of wounds. Where the wound care nurse had seen a resident there was a short term care plan in place for the management of the wound.

Evaluation – Standard 4.5

4.5.2: Partial Attainment: Moderate Risk
3 of 9 Life Style care plans had been reviewed and updated as a result of the evaluation. There were examples of life style plans that required evaluation as they were no longer current and did not record progress made towards desired goals.

Planned Activities – Standard 4.6

4.6.1: Partial Attainment: Moderate Risk
There is an activities programme delivered by a trainee diversional therapist (this staff member stated that she was a quarter of the way through the programme) who has been working in the capacity as the activities officer for the last six months. The programme delivered provides a limited range of activities.

Staff and relatives commented that there are insufficient activities available for residents and that there is little for residents to do after the activities officer leaves for the day or on the weekends.

4.6.2: Partial Attainment: Moderate Risk
Planned activities are limited. The activities officer has not developed individual plans for all residents that can be implemented either with or without the assistance of staff.

4.6.3: Fully Attained
Preferences are sought through discussion with residents and their family through completion of a social history.

Review - Standard 4.9

4.9.1: Fully Attained
There have been some recent significant changes to service delivery as a result of a review undertaken by the owner and management in response to complaints received. This is supported by an action plan.

Recording Systems – Standard 5.2

5.2.5: Partial Attainment: Low Risk
Incident and accident records were not retained within the clinical file. Needs Assessment records were not held in the clinical file. There was no cross referencing to indicate what is archived and when it should be archived (e.g. Needs Assessment records, admission agreements)

Medicine Management – Standard 5.3

5.3.1: Partial Attainment: High Risk
As needed (prn) medicines prescribed by a registered medical practitioner did not include prescription of the dose and frequency for administration. The registered nurse had entered this information into the medicine profile.

There were prescribed medicines present that were for people no longer resident at the facility.

There were at least six decanted medicines some of which are prescribed medicines. The decanted medicines were put into urine specimen containers and were labelled with the name of the preparation.

There were prescribed medicines (e.g. Locoid) that were not labelled with a resident's name or instructions for the administration of the product.

In correspondence received by the Ministry of Health subsequent to the audit, the following actions have been noted by the facility:

- MOH Safe Medicine Management Book ordered
- All prescription medications, ointments, creams not in use or not prescribed have been returned to pharmacy
- Medicines no longer required are kept in a sealed container until they are returned to pharmacy
- A medication book for pharmacy transactions has been established
- Medicine education for staff is scheduled for 9th and 13th March 2009
- Medication competencies for staff are to be repeated
- Monthly medication audits will occur until compliance indicates 98% before returning to a bi-monthly audit schedule
- Implementing Douglas Medication prescription and prescribing charts for respite residents
- Blister packaging for any respite residents spending more than two weeks at the facility
- Ensuring all medicine prescribing is signed by a Registered Medical Practitioner
- Discontinued prescriptions are signed as discontinued by a Registered Medical Practitioner

Nutritional and Safe Food Management – Standard 5.4

5.4.1: Fully Attained
There is a winter and summer menu. The menus have been reviewed by a dietitian. There has been a recent addition of a second afternoon tea and high protein snacks.

5.4.2: Fully Attained
Special dietary needs had been noted by the cook. The cook prepares meals according to the special needs of residents that require special or modified diets.

5.4.3: Fully Attained
Preferences had been identified and recorded. The cook refers to preferences and adjusts the menu accordingly.

5.4.4: Partial Attainment: Low Risk
There has not been any temperature testing at the point of food service.
Other aspects of food procurement, production and storage of food are consistent with current accepted practice. There has not been temperature testing of food transported to the facility that is perishable or frozen. The cook reported that frozen and perishable items are delivered in a chiller and the driver has direct access to the freezer and fridge.

Cleaning and Laundry Systems – Standard 5.5

5.5.1: Fully Attained
Written protocols were not reviewed. The cleaner and laundry cleaner stated that there were material data sheets available from the chemical supplier.

5.5.2: Partial Attainment: Moderate Risk
An internal audit or other process conducted by the facility to monitor the effectiveness of cleaning and laundry processes was not available on the day of audit.

Infection control management – Standard 5.6

5.6.1: Partial Attainment: Moderate Risk
Disposable syringes had been cleaned and re-used for the administration of medicines.

Soiled and clean laundry was found to be mixed in the laundry area.
The dirty clean flow in the laundry could not be achieved with the current layout and configuration of equipment.

Damp washed laundry was left and had not been dried in a timely manner.
There were items of clothing that had been left soaking in buckets. There was no information as to the product they were soaking in or for the length of time the items should be soaked for.

Management of waste and hazardous substances – Standard 5.7

5.7.7: Fully Attained
There were disposable gloves and aprons present in bathrooms and the laundry.

Physical Privacy – Standard 6.1

6.1.1: Partial Attainment: Low Risk
Not all shared rooms provided for privacy as there was limited or no curtaining.

6.1.2: Fully Attained
Staff were observed to be respectful of resident's privacy. For example knocking on resident room doors before entering, the room, returning personal items to rooms that had been taken by wandering residents.

6.1.3: Fully Attained
There is curtaining in addition to doors for each toilet and bathroom area.

Facility Specifications – Standard 6.2

6.2.3: Partial Attainment: High Risk
One resident room had a bolt to the top of the door.

Summation meeting

A summation meeting was attended by XXX XXX, Manager and XXX XXX, Registered Nurse, XXX XXX and XXX XXX. The meeting commenced at 4.55 pm and concluded at 5.25 pm

XXX thanked XXX and her staff for their cooperation throughout the audit process. XXX noted that the new manager had made significant changes to address many of the concerns raised in the complaints made to the Health and Disability Commissioner.

The following matters in relation to the complaints have been remedied:

- Staffing levels
- Management of residents personal items and clothing
- Competence of the manager

The following allegations could not be substantiated through the audit process:

- Lack of personalization of rooms
- High turnover of staff
- Competence of the previous manager
- Lack of cleanliness of the facility

As the manager and registered nurse had been newly appointed and there had not been a complaint since their appointment, the appropriate implementation of the complaints management process could not be verified.

In order to complete the audit, further information was requested in relation to staff training and skill sets. One week was given in order to provide this information.

XXX presented the audit findings.

The following high risk findings were discussed as needing immediate action:

- Medicine Management
- Staffing systems for allocating staff to individual residents for each shift
- Removing the bolt from the resident door

A recommendation was also made in respect to Health and Disability Sector Standard 6.1.3 that privacy for residents using the toilets located in the corridor would have privacy enhanced if the doors opened outwards allowing easy closure of the door when a walker or care giver is also in the toilet cubicle with a resident.

The manager acknowledged the presentation of the findings and thanked the HealthCERT officials for their approach to the audit.

Conclusion

The inspection of Wattledowns Holdings Limited found that the following aspects of the complaints made to the Health and Disability Commissioner were upheld:

- Unacceptable standards of care (personal hygiene, management of challenging behaviour, activities and exercise)

- Lack of involvement of family in care planning including communication of incidents and accidents to family
- Inadequate behavioural assessment of residents
- Inadequate management of continence
- Weight loss of residents
- Lack of personal privacy for residents
- Infection control issues
- Insufficient care giver training (not withstanding further information being provided by the facility as requested)

It is possible that other aspects of complaints were present at the time the complaints were made but could not be verified through the audit process. There was also insufficient management of complaints made directly to the facility prior to the appointment of the new manager and a finding has not been made for this reason.

As noted in this report, there have been significant changes made by the facility since the internal investigation commenced in November 2008 that have contributed to addressing some of these issues. The facility also has an active action plan in place but will need to amend this to include the findings made in respect 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 Whanganui District Health Board and the Health and Disability Commissioner.

Appendix

Documents reviewed

- Staffing and skill mix policy
- Management of challenging behaviour policy
- Assessment and care planning policy
- Entry to 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 month and next month)
- Staff training records and in-service training programme
- Minutes of staff meetings
- Minutes of quality meetings
- Assessment tools
- Resident files
- Completed resident satisfaction survey