Final Inspection Report

Whangaroa Health Services Trust

Date of Inspection: 4 March 2010

HealthCERT
Quality & Safety
Regulation and Governance
Ministry of Health

Contents

Undertaken:	**4 March 2010**
File Ref:	**WWH06**
Provider:	**Whangaroa Health Services Trust**
Contact Person:	**Mr XXX XXX**
Premise:	**Whangaroa Health Services** **180 Omaunu Road** **RD2** **KAEO**

Executive Summary

History

Whangaroa Health Services Trust is certified to provide Hospital (Geriatric & Medical) care services and Rest Home services for a period of 3 years, expiring on 1 June 2012.

Before this, the provider applied for certification in May 2004 and was certified for three years. In the 2004 certification audit there were no partially attained criteria identified which required corrective action reporting. In the 2007 certification audit, there were 18 partially attained criteria that required corrective action reporting. A certification was issued for 2 years. In the 2009 certification audit there were 11 partially attained criteria and one continuous improvement, certification was issued for 3 years.

An unannounced surveillance audit is due to be carried out three months either side of November 2010.

Previous Recent Complaints

There have been no known complaints for this provider.

Nature of current complaint

The Ministry of Health has received an anonymous complaint via XXX about the healthcare services provided by the Whangaroa Health Services Trust. If substantiated, such concerns may be in breach of the Whangaroa Health Services Trust's obligations as a certified provider under the Health and Disability Services (Safety) Act 2001 (the Act).

In summary, the complainant alleged that:

- Complaints are not managed appropriately
- Clinical governance is of a poor standard
- Staffing levels are low and the skill mix is not appropriate
- The Maori culture is not respected by management
- Quality and risk management systems have been compromised by management changes
- Patients' privacy is not respected
- Medication may have been over-prescribed.

The complaint related but was not limited to the following Health and Disability Services Standards (2008):

- 1.1.4 Recognition of Maori Values and Beliefs
- 1.1.13 Complaints Management
- 1.2.1 Governance
- 1..2.3 Quality and Risk Management Systems
- 1.2.7 Human Resource Management
- 1.2.8 Service Provider Availability
- 1.3.3 Service Provider Requirements
- 1.3.12 Medicine Management

Further information (DHB/HDC)

The Northland District Health Board (DHB) Health of Older Persons Portfolio Manager, XXX XXX, was contacted concerning this complaint and although there were no current concerns or complaints for this facility, she was aware of the following:

January 2009, there were five deaths at the facility, a higher level than normal. These were all from natural causes.

October 2009, union negotiations for remuneration for staff reached a "withdrawal of goodwill" from the union, potentially compromising staffing levels.

There is an ongoing dispute between the PHO and the Kaeo Pharmacy which is being addressed by the DHB.

Service Description

Whangaroa Services Trust provides Aged Residential Care, Hospital – Medical and geriatric services, and Rest Home services. The occupancy and capacity is outlined below:

Area	Occupied	Capacity
Hospital	10	10
Rest Home	11	10
Total	**21**	**20**
Note: The facility has one respite bed, and will apply for increased capacity for this.		

Reasons for the inspection

The purpose of the inspection was to determine whether health care services provided by Whangaroa Health Services Trust were in compliance with section 9 of the Act. That is, a person providing health care services of any kind must do so whilst meeting all relevant standards.

Health and Disability service providers are required under 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 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 Registered Nurse (Facility Coordinator, Elderly Services)
- 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 limited to the issues raised in the complaint.

Entry Meeting

Present: XXX XXX, HealthCERT, XXX XXX, HealthCERT, XXX XXX, General Manager, XXX XXX, Elderly Services Manager.

The introduction meeting covered the following points:

A copy of the letter of introduction addressed to XXX XXX was provided to him.

A proposed agenda for the day was discussed including a request to interview any relatives or health professionals visiting the facility during the course of the day. The inspection commenced with a tour of the facility.

Summary of Inspection findings

Summary of findings where non-compliance to the Health and Disability Services Standards has been identified specific to the complaint and inspection.

Consumer Rights during Service Delivery - Standard 1.1

1.1.4.1- Maori consumers receive services consistent with their cultural values and beliefs.

Fully Attained
Four residents identified as Maori and one did not wish to be involved with Maori culture. Maori staff members are able to converse in Te Reo.

1.1.4.2- Maori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Fully Attained
When confirmed that this is desired, staff make arrangements for this to occur.

1.1.4.3 - The organisation plans to ensure Maori receive services commensurate with their needs.

Fully Attained
The Cultural Safety Policy for Maori is based on Te Whare Tapa Wha and is supported by Whangaroa Health Services' procedure Nga Kaupapa Matua.

1.1.4.4 - Maori consumers right to practice their cultural values and beliefs while receiving services is acknowledged and facilitated by service providers.

Fully Attained
As per above policy. There is also affiliation with eleven Marae in the region.

1.1.4.5 - The importance of whanau and their involvement with Maori consumers is recognised and supported by service providers.

Fully Attained
Evidenced in care plans and activity planning.

1.1.4.6 - Tangata whenua are consulted in order to meet the needs of Maori consumers.

Fully Attained
Own staff, and whanau, Kaumatua and Kuia are available from Marae in the area.

Complaints Management – Standard 1.13

1.1.13.1 – The service has an easily accessed, responsive and fair complaints process, which complies with Right 10 of the Code.

Fully Attained
There is a comprehensive complaints procedure, which is adhered to when a complaint is made.

1.1.13.2 – Information about a consumer's right to complain and the process is available.

Fully Attained
Complaint forms were available at the main entrance to the facility.

1.1.13.3 - An up-to-date register is maintained that includes all complaints, dates and actions taken.

Fully Attained
The complaints register is clear, meets policy timeframes and includes resolution of complaints.

Organisational Management - Standard 1.2

1.2.1.1 - The purpose, values, scope, direction and goals of the organisation are clearly identified and regularly reviewed.

Fully Attained
The Operations and Policies manual clearly identified the purpose, scope, goals and direction of the organisation. This is reviewed annually at Board meetings.

1.2.1.2 – Organisational performance is aligned with and regularly monitored against the identified values, scope, strategic direction and goals.

Fully Attained
CEO attends monthly Board meetings, and provides a comprehensive report which aligns with the direction of the organisation.

1.2.1.3 – The organisation is managed by a suitably qualified and experienced person.

Fully Attained
The Chief Executive Officer is suitably qualified, and has a Diploma in Quality Management. The clinical leaders are both Registered Nurses with Aged Care experience.

1.2.3.1 –The organisation has a quality and risk management system, which is understood and implemented by service providers.

Fully Attained
The risk management plan identifies the risk matrix and risk level. It is current and is reviewed biennially.

1.2.3.2 – Management and service providers enables consumer participation and consultation wherever appropriate

Fully Attained
Residents observed were happy and engaged in meaningful activity. Annual resident satisfaction surveys are undertaken, which allows resident feedback.

1.2.3.3 – The service develops and implements policies and procedures that are aligned with current good practice and service delivery, met legislative requirements, and are reviewed at regular intervals.

Fully Attained
There is a robust policy review system, and the sample of policies reviewed met legislative requirements.

1.2.3.4 – There is a documented control system to manage policies and procedures.

Fully Attained
The review system is colour coded – with 'white' policies under review or due for review. 'Blue' policies have been through the review process and are signed off. All policies sighted had footer with dates, sign authorisation and version number.

1.2.3.5 – Key components of service delivery shall be explicitly linked to the quality management system.

Fully Attained
The Quality plan links all aspects of service delivery, there are policy statements on each aspect of the Health and Disability Services Standards within the Quality Plan.

1.2.3.6 – Quality improvement data are collected analysed and evaluated and the results communicated to service providers and where appropriate, consumers.

Fully Attained
There is a robust internal auditing schedule for 2010. There is a policy on internal auditing, and review, which includes analysis, corrective action plan and follow up.

1.2.3.7 – A process to measure achievement against the quality and risk management plan is implemented.

Fully Attained
The internal audit system is linked to the Quality Plan, compliance and non-compliance is noted on the audit plan.

1.2.3.8 - A corrective action plan addressing areas requiring improvement in order to meet with specified standard or requirements is developed and implemented.

Fully Attained
Where a corrective action plan is required following an internal audit, this is documented and followed up by the Quality Coordinator.

1.2.3.9 – Actual and potential risks are identified, documented and where appropriate communicated to consumers.

Fully Attained
There is a robust risk management plan. Where internal audits have identified deficits, a corrective action plan is documented for follow up and action. Feedback is then noted.

1.2.7.1 – The skills and knowledge required of each position are identified.

Fully Attained
There are job descriptions for each position and these are updated as necessary.

1.2.7.2 – Professional qualifications are validated including evidence of registration and scope of practice for service providers.

Fully Attained
Annual practicing certificates for professional staff are sighted and held on individual staff files.

1.2.7.3 – The appointment of appropriate service providers to safely meet the needs of the consumers.

Fully Attained
The Registered Nurses are well prepared to meet client needs. All Registered Nurses have current IV Certification, which is updated biennially, and also trained annually in Prime response. This is not specifically required for the residential component of their position, but the rural nature of their facility and being attached to the PHO service.

1.2.7.4 – New service providers receive and orientation/ induction programme that covers the essential components of the service provided.

Fully Attained
There is a planned orientation programme and non professional clinical staff are encouraged to commence and complete external education, through ACE. Compulsory training days are planned for all staff, relating to, for example, fire safety procedures and infection control.

1.2.7.5 – A system to identify, plan, facilitate and record ongoing education for service providers.

Fully Attained
Individual staff education records are held electronically and updated as required. The Quality Coordinator updates the records.

1.2.8.1 – There is a documented and implemented process which determines service provider levels and skill mixes in order to provide safe delivery.

Fully Attained
There is a rationale for staff skill mix, and the rosters sighted provided enough service providers to ensure consumers are cared for appropriately.

Continuum of Service Delivery - Standard 1.3

1.3.3.1 - Each stage of service provision (assessment, planning, provision, evaluation, review and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform this function.

Fully Attained
Initial assessments carried out as per policy, competent staff available for this, and carried out within policy timeframe.

Care plan format has been recently reviewed and are clear and easily readable for all staff. The 3 and 6 monthly reviews are carried out in depth and care plans adjusted following this process or as required due to changes in resident condition.

1.3.3.2 - Each stage of service provision (assessment, planning, provision, evaluation, review and exit) is developed with the consumer, and where appropriate their family/whanau of choice or other representatives as appropriate.

Partially Attained - Low
Initial assessments are carried out with residents or whanau. Evidence of family being contacted and open disclosure policy working well.

Finding:
No evidence in care plan of resident/whanau involvement, although this does occur.

Corrective Action:
Ensure that involvement of resident/whanau in care planning is carried out and documented.

1.3.3.3 - Each stage of service provision (assessment, planning, provision, evaluation, review and exit) is provided within time frames that safely meet the needs of the consumer.

Fully Attained
All reviews carried out as per policy - six and twelve months reviews were very thorough, and there is input from a multidisciplinary team.

1.3.3.4 - The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Fully Attained
Excellent access to multidisciplinary team members, as most are on site, at the PHO clinic.

1.3.12.1 - A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines.

Partially Attained - Moderate
Sound policy and procedures in place with some findings.

Medico blister pack system in use, staff requires competency checks to administer medication (RN) and care staff for witnessing Controlled Drug administration.

Medicines management is very good with some exceptions, the medication storage and administration process is very well organised, the local medication charts and signing sheets, need to be reviewed to be inclusive of 3/12 reviews and PRN medications, Insulin, warfarin etc.

Findings:
Policy requires Registered Nurses to enter 6/12 expiry date onto medication delivered from pharmacy without such dating. This policy was reviewed with input from the Pharmacist.

Policy requires the Registered Nurse to amend by hand any incorrect labelled days on the blister packs. This policy was reviewed with input from the Pharmacist.

Policy requires Registered Nurse to dispose of expired/discontinued drugs (including controlled drugs) into the yellow sharps container. This policy was reviewed with input from the Pharmacist.

Corrective Actions:
Ensure that policy and procedure for receipt of medications does not require RNs to work outside their scope of practice.

Ensure that medication destruction policy and practice is as per legislation.

1.3.12.2 - Policies and procedures clearly document the service providers responsibilities in relation to each stage of medicine management.

Fully Attained
Policies are clear and easily understood, and have linkages to each other.

1.3.12.3 - Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Fully Attained
Medico blister pack system in use, staff are required to undertake competency checks to administer medication (RN) and care staff for witnessing CD administration.

1.3.12.4 - A process is implemented to identify, record, and communicate a consumers medicine related allergies or sensitivities and respond appropriately to adverse reactions or errors.

Fully Attained
Policy addresses this requirement, and the 3 and 6 monthly reviews are thorough. Due to the PHO Clinic proximity a GP is available for reference and to respond. There was no evidence of overuse of PRN medications or over-prescribing.

1.3.12.5 - The facilitation of safe self-administration of medicines by consumers is appropriate.

Fully Attained
Policy addresses this requirement, no residents self administering currently, so could not be evidenced.

1.3.12.6 - Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Fully Attained
Policy addresses this, and resident/whanau informed, and all changes are noted within progress notes, there is an information sheet which also noted whanau being communicated with.

Summation meeting

A summation, meeting was attended by XXX XXX, HealthCERT, XXX XXX HealthCERT; XXX XXX, General Manager, XXX XXX, Elderly Services Manager, XXX XXX-XXX, Elderly Services Co-ordinator, XXX XXX, Quality Facilitator.

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 would be provided at the closing meeting. XXX noted that staff were approachable and welcoming. She confirmed that there would be findings against the Health and Disability Services Standards with regard to medication management and lack of evidence in resident/whanau participation in care planning.

Key issues raised at summation were:

Relevant to complaint: Nil.

Not relevant to complaint:

1.3.3.2 - No evidence of resident/whanau involvement in care plans.

1.3.12.1. Policy requires Registered Nurses to enter 6/12 expiry date onto medication delivered from pharmacy without such dating. This policy was reviewed with input from the Pharmacist.

Policy requires the Registered Nurse to amend by hand any incorrect labelled days on the blister packs. This policy was reviewed with input from the Pharmacist.

Policy requires Registered Nurse to dispose of expired/discontinued drugs (including controlled drugs) into the yellow sharps container. This policy was reviewed with input from the Pharmacist.

Conclusion

Whangaroa Health Services Trust is required to take the above corrective actions to be compliant with the Health and Disability Services Standards. Ongoing monitoring will be undertaken by the Ministry of Health in conjunction with the District Health Board.

The anonymous complaint via XXX about the healthcare services provided by the Whangaroa Health Services Trust alleged that:

- Complaints are not managed appropriately
- Clinical governance is of a poor standard
- Staffing levels are low and the skill mix is not appropriate
- The Maori culture is not respected by management
- Quality and risk management systems have been compromised by management changes
- Patients' privacy is not respected
- Medication may have been over-prescribed.

All the above allegations were found to be unsubstantiated.

Additional Conditions

Additional conditions to be placed on the Certification Schedule:

1. A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards: 1.3.3.2; 1.3.12.1 as identified in the Inspection Report must be submitted to the Director-General by 30 June 2010.

2. HealthCERT may elect to carry out a verification audit in relation to these corrective actions.

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

Summary for Publication

As this complaint was not substantiated no summary for publication is required.

Appendix

Documents requested

Policies:

- Abuse and Neglect
- Adverse event reporting
- Complaints management
- Medication policy
- Staff levels and skill mix
- Staff orientation

Documents:

- Complaints records for 2009 and 2010
- Manager Trust Board reports
- Minutes of staff meetings
- Quality and Risk Management Plan
- Residents files(Sample number)
- Resident satisfaction surveys.
- Staff rosters (last month and this month)
- Staff Education records