Inspection Report

Kiwiannia Care Limited

Granger House Rest Home &

Richard Seddon Hospital

Kowhai Manor

Date of Inspection:

1 & 2 September 2015

HealthCERT
Clinical leadership, Protection and Regulation
Provider Regulation
Ministry of Health

1. Table of Contents

Contents

2. Provider Details

Certificate:	Two year: 01 April 2015 – 01 April 2017
Premises:	Granger House Rest Home & Richard Seddon Hospital
Premises Address:	117 Shakespeare Street
Contact Person:	[redacted]
Internal Ref:	
Inspection Date:	1 September 2015

Certificate:	Two year: 01 April 2015 – 01 April 2017
Premises:	Kowhai Manor
Premises Address:	24 Threadneedle Street
Contact Person:	[redacted]
Internal Ref:	
Inspection Date:	2 September 2015

3. Executive Summary

The Ministry of Health received information which alleged Kiwiannia Care Limited could be in breach of its obligations as a certified provider under the Health and Disability Services Act (2001) to provide services at Granger House Rest Home & Richard Seddon Hospital, and Kowhai Manor.

On receipt of the information, the Canterbury District Health Board (DHB) contacted the Ministry to discuss the concerns raised. The concerns related to systemic issues across the quality and risk system, including incident reporting; staffing including recruitment and orientation; and clinical care of residents. A decision was made by the Ministry and DHB to undertake an unannounced inspection to assess aspects of the relevant Health and Disability Services Standards (2008).

The inspection was completed on 1 September 2015 at Granger House Rest Home & Richard Seddon Hospital and on 2 September 2015 at Kowhai Manor. The inspection was completed by the Ministry in accordance with sections 40, 41, and 43 of the Act. Two gerontology nurse specialists from Canterbury DHB were also on the inspection team.

The focus of the inspection was to assess the implementation of the quality and risk framework, staff recruitment and management, and, that clinical care was being completed to the required standard. In addition the inspection team considered complaint management, restraint practice and suitability of equipment and resources. The inspection team reviewed 16 resident clinical files, interviewed 18 staff and undertook conversations with residents and families.

On the basis of the evidence reviewed during the inspection, Granger House Rest Home & Richard Seddon Hospital and Kowhai Manor did not fully comply with 13 of the Health and Disability Services Standards (NZS 8134:2008). The partially attained standards related to: best practice, complaints management, governance, quality and risk framework including incident reporting, human resource management, staffing, clinical record documentation, assessment and care planning, medication management, safe restraint practice and availability of equipment. Safe restraint practice is considered to be high risk and requires urgent attention.

In addition observations were made in respect of the activities programme and food services.

Ongoing monitoring will be undertaken by the Ministry in conjunction with the Canterbury DHB.

The provider reported progress in addressing some of the partially attained standards from previous audits, in both homes, has been impacted by the need to accommodate 20 extra residents who were transferred from Hokitika as a result of floods in Hokitika in June.

4. Background

Law:

Providers of health care services must be certified by the Director-General of Health (Sections 9(a) and 26 of the Act) and must comply with all relevant health and disability service standards (Section 9(b)).

The relevant service standards are approved under the Health and Disability Services (Safety) Notice 2008. The standard approved is the Health and Disability Services Standards NZS 8134:2008.

Facts:

a) Governance

Granger House Rest Home & Richard Seddon Hospital (Granger) and Kowhai Manor (Kowhai) are owner operated. Although the owner was unable to be present at the time of the inspection, a brief telephone discussion was undertaken on Day 1.

A newly appointed manager was scheduled to commence on the day of inspection; however her start date has now moved to 8 September. The incumbent's personnel file was unable to be reviewed; however she is reportedly a registered nurse with experience in the aged care sector. It is noted there has been three people having held the role in short succession.

Granger provides rest home and hospital level care for up to 69 residents. On the day of the inspection there were 24 rest home, 32 hospital (including seven residents from The Ultimate Care Group – Allen Bryant). There were two respite residents (rest home) and one person under 65 yrs. Kowhai provides rest home and hospital level care for up to 41 residents. On the day of the inspection there were 22 rest home and 20 hospital level care (including eight residents from The Ultimate Care Group – Allen Bryant).

Kowhai had a clinical leader (registered nurse with current annual practising certificate) employed fulltime. The clinical leader position had two rostered 'paper work days' and three days operating as the registered nurse on the floor. There would be benefit in having a dedicated clinical leader whose responsibility is to support the Kowhai workforce and clinical care.

Granger did not have a clinical manager position at the time of the inspection and clinical leadership and support at this facility requires attention.

b) Quality and Risk Management Systems (Granger & Kowhai)

Granger and Kowhai demonstrated aspects of a quality management system were in place, however, overall the quality framework required strengthening to be fully implemented. A Quality and Risk Management Plan (April 2014, review 2017) was reviewed, and updates towards goals sighted. Aspects of the framework had been centralised to the Granger site including complaints management, incident analysis and trending, and recording of staff education.

The complaint log/register was reviewed at Granger. The majority of complaints recorded for the 2014 year did not include action taken and/or resolution, noting there was one complaint recorded in 2015 that did include close out detail. There was one complaint entry in the folder that was dated 25 November 2015 (link finding 1.1.13).

There was a suite of policies. At Granger, the clinical policies could not be located on the day of the inspection, a small number were reviewed at Kowhai on Day 2. Staff interviewed on both sites were aware there were policies to guide practice, however there were instances where policies were not being implemented as prescribed – eg. handover sheets were required to be kept for a prescribed period of time, in Granger these were being shredded at the end of the shift. In addition policies need to be reviewed to ensure they meet current best practice – eg. the Skin Management policy stated: *massage bony prominences regularly with aqueous cream*. There were also practices recorded in resident plans that do not meet best practice – eg. giving juice to a resident with a syringe (link finding 1.1.8).

There were a number of internal audit templates at both sites. At Granger the completed audits for 2015 could not be located. Kowhai had completed the internal audit programme as prescribed, however there were a number of 'Audit Outcome Forms' (corrective actions) that had not been completed and closed out.

Comprehensive meeting minutes were not available at either site. Resident meeting minutes were available at Granger bimonthly for the current year, however at Kowhai the last available were dated March 2015. The minutes reviewed did not consistently record follow up of issues raised. Staff meetings at Granger were reportedly held, however minutes were not readily available for the last four months. Kowhai had staff and registered nurse meeting minutes available. These should be strengthened to include discussion of incident trends and mitigation strategies, and internal audit outcomes at a minimum. There was a current hazard register, however, the last health and safety meeting minutes sighted were dated March 2015.

Data analysis and trending is reportedly being undertaken, this information was not seen to have been discussed at the staff meetings of the minutes reviewed. It is acknowledged staff informed they were told of the number of falls (for example) at staff meetings (Granger).

c) Adverse Event Reporting (Granger & Kowhai)

Incident forms were completed for resident (and staff) events at both sites. The original incident forms were kept at Granger. For those incidents reported at Kowhai, it is recommended the original form is kept on site with the resident files, and a photocopy is sent to Granger for data entry and monthly trending.

It is acknowledged aggregating and trending of data has recently commenced (electronic), however detailed analysis of individual 'frequent fallers' was not evidenced such as time of day/location. This may prove particularly helpful in reducing the falls rate at Granger – 41 recorded falls April. A Falls Response Protocol was used inconsistently (Granger) and does not link to policy (refer finding 1.2.3). There were monthly logs being used to collate incidents at both sites. There were instances where incidents reported did not appear on the appropriate log (Granger), and months where completion of a log was not evident (Granger - no log for April and May 2015). The majority of incidents occurring in the past three months at Granger had not been signed off by a manager.

d) Human Resource Management (Granger & Kowhai)

All staff files are held at Granger. Six staff files were reviewed, including one registered nurse with a condition placed on her practice by the Nursing Council of New Zealand. Review of the file indicated that while there had been an appropriate mentor/supervisor in place, at the time of the inspection, this was no longer the case and the Nursing Council were notified.

Relevant documentation was seen on files. Completed orientation was evident in staff files reviewed. Performance appraisals were not current for 2015 and the clinical leader (Kowhai) confirmed there were appraisals overdue for Kowhai staff. There was regular training being offered and medication competencies were current. The education programme could be strengthened, particularly for the registered nurse workforce, by considering opportunities at the local district health board. The registered nurses were first aide trained.

e) Service Provider Availability (Granger & Kowhai)

There was a staffing rational policy that noted the *Nurse Manager* acts as the nurse on call. Interviews with staff at both sites were unclear of on call arrangements.

Rosters were available at both sites. At Granger, since the recent resignation of the quality manager (the previous week) rosters had been developed by two staff - a healthcare assistant (HCA) completed the HCA roster and a registered nurse (RN) the RN roster. This meant that oversight of staff numbers and skill mix per shift was not implemented in a coordinated fashion.

Interview with staff and relatives informed unexplained absence (i.e. sickness) was not always backfilled – review of rosters at both sites confirmed this to be the case. Senior staff interviewed informed attempts are made to backfill staff absence.

f) Clinical Documentation (Granger & Kowhai)

Sixteen files were reviewed across both sites. Overall the documentation was of a reasonable standard with assessments leading to care plans. Interventions were

recorded in the progress notes. There were a number of examples where assessments, care plans and documentation were not meeting the required standard. Some examples include:

- progress notes for hospital residents were not always recorded by a registered nurse in a 24 hour period (Kowhai). There were instances where care plan updates were not dated and/or signed

- pain assessments were not always completed when pain had been reported

- GP initial assessment was not completed within 48 hours of admission

- long term care plans were not sufficiently comprehensive to clearly articulate resident needs. In addition aspects such as toileting regimes, supra pubic catheter care, de-escalation techniques and recommendations from allied health professionals were not always evident.

g) Service Delivery/Interventions (Granger & Kowhai)

Interview with staff at both sites inform there are ongoing issues accessing suitable equipment and supplies to perform their duties effectively and in a timely manner. At Granger staff informed there had been issue accessing appropriate wound dressing supplies and night bags for residents with indwelling catheters, and at Kowhai linen supplies were reportedly insufficient to meet the needs of residents. There were pieces of linen sighted during the inspection in need of replacement. Reportedly additional sensor mats would support resident safety (Kowhai).

During the inspection it was noted a hoist was in the process of being repaired, Kowhai staff informed seated scales had been, in the recent past, temporarily loaned to Granger. While it is reasonable to share equipment to meet resident need when malfunction occurs, it is recommended a reconciliation of equipment (and supplies) is undertaken in order to ensure there is sufficient equipment available to meet the care needs of residents.

h) Medication Management (Granger & Kowhai)

There were secure medication rooms at both sites and medication competencies for staff were current. Incidents relating to medication management were reported.

At Granger, controlled drugs are being administered appropriately, however, where the full ampule is not being administered, the amount being discarded is not being recorded. Interview with registered nurses indicated they were unaware of the requirement to record discarded controlled drugs.

Eighteen medication charts were reviewed and generally medication is managed in an acceptable manner at both sites. The following are improvements required in respect of charting: recording of allergies (or no allergies) on the medication chart, prn medication is being used regularly (and could be prescribed as a regular medication) and there were instances where no indications for use for prn medication are recorded, individual dates are not being recorded on prescription charts in a small number of cases.

i) Restraint (Granger)

At Granger there was significant use of restraint – lap belts, bed rails and environmental restraint. Based on the findings from this inspection this aspect of service delivery requires urgent and immediate attention.

Environmental restraint was observed in the Greenwood wing and staff referred to the 'dementia' residents residing the wing. The provider is not certified for dementia services and there are reportedly no residents assessed as requiring a secure environment at the time of inspection. It is acknowledged there were residents who had received DHB 'top-up' funding (in respect of dementia service), however at the time of audit all residents in this wing had been (re)assessed as requiring rest home level of care. The punch code lock restricting resident movement around the facility needs to be removed.

While one resident file was reviewed in depth in respect of restraint practice, observations and review of associated documentation (such as monitoring forms), indicated restraint issues were systemic in Granger. The file reviewed showed the resident had a lap belt on during the day while in a chair and side rails up at night. The restraint/enabler form had not been signed (or dated) by the resident's daughter and there was no signature by the GP. Documentation indicated a discussion had occurred. Restraint monitoring forms were available however not fully completed – e.g. an entry indicating restraint put on at 0200, and remained on all night. There was no position changes ticked on the chart. The monitoring chart dated 30 August indicated the lap belt was put on at 0700 and no indication the lap belt had been taken off all day. One 'walk' only was recorded. Observation of this resident demonstrated she was restless in her chair, however when approached and communicated with the resident settled.

A further observation was that of a resident in one of the lounges who had slipped in her chair resulting in the lap belt being at chest height. A member of the inspection team needed to seek registered nurse assessment to rectify the situation. In addition 'removing a residents frame to stop them walking' (as a falls minimisation strategy) could also be perceived as an attempt to restrict free movement and could constitute restraint.

Additionally the inspection team are of the view it is recommended bed rails are not used as restraint due to the potential risk to residents.

j) Observations

The following are additional observations. It is noted there was insufficient time during the inspection to fully consider these aspects of service delivery in order to determine compliance with the relevant standard.

Activity Programmes: based on resident interview there is the opportunity to review and enhance the activities programmes at both sites.

Food Services: based on resident interview and resident meeting minutes, food services would benefit from review. It is acknowledged the menu had been reviewed January 2015 by a dietician.

5. Inspection Team

The inspection was undertaken by [redacted], Senior Advisor, HealthCERT, Ministry of Health, under delegated authority of the Director-General of Health. [redacted], Gerontology Nurse Specialist and [redacted], Gerontology Nurse Specialist from the Canterbury DHB also attended.

6. Inspection Process

The following methodology was used during the inspection:

- interview with residents, staff and families
- observation of residents
- physical tour of the premise
- review of clinical records
- review of relevant policies and procedures.

7. Inspection Limitations

The scope of the inspection was limited to the issues raised in the information received in respect of the quality and risk management system and clinical care of residents.

8. Inspection Findings

Findings have been reported against the Health and Disability Services Standards (NZS 8134.1:2008):

Relevant Standard	Findings	Required Corrective Action	Rating and time frame.
Standard 1.1.8 Consumers receive services of an appropriate standard	The Skin Management policy: states: 'massage bony prominences regularly with aqueous cream'. This does not align to current best practice. Granger: There were practices sighted that are not considered to meet best practice such as giving juice to a resident with a syringe, residents being isolated inappropriately (for looking flushed) and removing a residents frame to stop them walking (and falling).	Clinical interventions and clinical policy adhere with best practice standards.	PA Moderate 90
Standard 1.1.13 The right of the consumer to make a complaint is understood, respected, and upheld	There was a complaints folder with a log in place. The majority of complaints recorded for the 2014 year did not include action taken and resolution. There was one complaint entry in the folder that was dated 25 November 2015.	The complaints log/register maintains an accurate record of complaints received and includes outcome and close out dates.	PA Low 180
Standard 1.2.1	A newly appointed manager was	Recruit a suitably qualified	PA Moderate

Relevant Standard	Findings	Required Corrective Action	Rating and time frame.
The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers	scheduled to commence on the day of inspection; however start date has now moved to 8th September. The incumbent's personnel file was unable to be reviewed. Granger did not have a clinical manager position at the time of the inspection, and clinical leadership and support at this facility requires attention. The clinical leader at Kowhai is the registered nurse on the floor three days per week.	manager. Establish a clinical model across both services to support clinical care, Granger in particular requires attention in this regard.	60
Standard 1.2.3 The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles	There were a suite of policies; however these could not be located at Granger. Those reviewed at Kowhai on Day 2 indicated policies were not being implemented as prescribed – e.g. handover sheets are required to be kept for a prescribed period of time, in Granger these were being shredded at the end of the shift. In addition policies need to be reviewed to ensure they meet current best practice (link finding 1.1.8). There are a number of internal audit templates at both sites. Completed audits were not available at Granger for 2015. Where an internal audit had been completed, 'Audit Outcome Forms' (corrective actions) were either not completed, or not closed out (Kowhai). Comprehensive meeting minutes were not available at either site.	Fully implement the quality and risk management system, and maintain appropriate records	PA Moderate 60
Standard 1.2.4 All adverse, unplanned, or untoward events are systematically recorded by the service and report to affected consumers and where appropriate their family/whanau of choice in an open manner.	As part of centralising systems, the original incident forms were kept at Granger for both sites. A photocopy of the incident form for Kowhai events was retained on the resident file. Some aggregating and trending of data had recently commenced (electronic), however detailed analysis of individual 'frequent fallers' was not evidenced such as time of day/location - Granger recorded 41 falls April. There were monthly logs being used to collate incidents at both sites. There were instances where incidents reported did not appear on the appropriate log (Granger), and months where completion of a log was not evident (Granger - no log for April and May 2015). The majority of incidents occurring in the past three months at Granger had not been signed off by a manager.	Ensure incident forms are signed off. Collation and analysis of incidents is to be strengthened in order to identify opportunities to manage individual resident risk. Review the practice of keeping the original incident forms for Kowhai residents at Granger.	PA Moderate 60
Standard 1.2.7	Six staff files were reviewed and	Performance appraisals are	PA Moderate

Relevant Standard	Findings	Required Corrective Action	Rating and time frame.
Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	performance appraisals were not current. Kowhai clinical leader confirmed there were appraisals for Kowhai staff that were overdue. The file of a registered nurse with a condition placed on her practice by the Nursing Council of New Zealand was reviewed. A suitable supervisor/mentor was not in place at the time of the inspection and the Nursing Council were notified. An education programme is being implemented. There is an opportunity to strengthen the registered nurse training.	completed annually. Staff are to work within their scope of practice. Registered nurse training opportunities could be strengthened.	90
Standard 1.2.8 Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	There was a staffing rational policy that noted the Nurse Manager acts as the nurse on call. Interview with staff at both sites indicated they were unclear of on call arrangements. At Granger since the recent resignation of the quality manager (the previous week) rosters had been developed by two staff - a healthcare assistant (HCA) completed the HCA roster and a registered nurse (RN) the RN roster. This meant that oversight of staff numbers and skill mix per shift was not being coordinated. Interview with staff and relatives informed unexplained absence (ie. Sickness) was not always backfilled – review of rosters at both sites confirmed this to be the case. Staff indicated attempts to backfill were generally made. Note the comment against 1.2.1 re clinical leadership at Granger.	Clarify on call arrangements. Review staffing levels. Rosters are developed by a suitably qualified person.	PA Moderate 30
Standard 1.2.9 Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	In Kowhai files there were examples where progress notes for hospital residents were not always documented by a registered nurse within a 24 hour period. In Granger files there are instances where care plan updates were not dated and/or signed.	Registered nurses document progress in residents' files as required. Documentation is dated and signed as required.	PA Low 90
Standard 1.3.4 Consumers' needs, support requirements, and preferences are gathered and recorded in	In files at both sites, pain assessments were not always completed when pain has been reported and GP initial assessment was not always completed within 48 hours of admission.	GP initial assessment is completed within 48 hours of admission. Pain assessment is completed when pain is reported.	PA Low 90

Relevant Standard	Findings	Required Corrective Action	Rating and time frame.
a timely manner.			
Standard 1.3.5 Consumers' service delivery plans are consumer focused, integrated and promote continuity of service delivery.	In files at both sites long term care plans (LTCP) were in place however there were examples where the LTCP was not comprehensive enough to clearly articulate resident needs.	Long term care plans are accurate and reflect resident needs.	PA Moderate 90
Standard 1.3.6 Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes	Interview with staff inform there were ongoing issues accessing suitable equipment (fully functioning hoists and scales) and supplies (including wound care supplies, linen, sensor mats) for the number and acuity of residents.	Appropriate equipment and supplies were available and in suitable working order for the clinical needs of residents.	Moderate 60 days
Standard 1.3.12 Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	At Granger, controlled drugs are being administered appropriately. However, where part of the ampule is not used, the volume being discarded is not being recorded. Interview with the registered nurses indicated they were unaware of the requirement to record discarded controlled drugs. The following are improvements required in respect of charting: recording of allergies (or no allergies) on the medication chart, prn medication is being used regularly and there are instances where no indications for use for prn medication is recorded, individual dates are not being recorded on prescription charts in a small number of cases.	Medication management adheres to best practice and legislation.	PA Moderate 60 days
Standard 2.3 Services use restraint safely	Granger: restraint practice requires urgent attention to ensure the least restrictive options are identified and implemented for residents. This includes (but not limited to): • there were times during the inspection Greenwood wing was keypad locked • restraint assessments were not signed by family and GP • restraint monitoring charts are not consistently up to date • alternatives to restraint are not consistently documented • one resident was observed to be in a compromised position during the inspection that required RN assistance • there was no evidence that toileting regimes (etc) were considered for residents in lap	Review restraint practice to ensure the least restrictive alternative is considered	High 30 days

Relevant Standard	Findings	Required Corrective Action	Rating and time frame.
	belts		

9. Meeting at the End of the Inspection

Present: Emma Prestidge, Manager HealthCERT; [redacted], Senior Advisor HealthCERT; [redacted], Projects Specialist, Canterbury DHB; [redacted], Gerontology Nurse Specialist; [redacted], Gerontology Nurse Specialist; [redacted], Clinical Leader, Kiwiannia; [redacted], Administration Manager, Kiwiannia; Hospitality Manager, Kiwiannia; [redacted], Nursing Director, Older People, Canterbury DHB (by phone).

Emma Prestidge and [redacted] thanked the facilities for their participation and approach to the investigation, recognising that this was an unannounced inspection. A summary of the findings were discussed at the closing meeting. The process was explained that a draft report would include a full description of findings. The draft report will be sent to the provider within 5 working days for any factual corrections. The provider was advised that this investigation report would be published on the Ministry of Health website.

The findings and observations in respect of the activity programme and food services (above) were discussed at the summation meeting.

10. Conclusion

Under Section 9 of the Act, certified providers must meet all relevant standards and comply with any conditions subject to which the provider was certified by the Director-General of Health. Kiwiannia is required to undertake the following corrective actions within the specified timeframes. If the corrective actions are not achieved, the Ministry may take action in relation to non-compliance with the requirements of the Act.

Required Corrective Actions

A written progress report that outlines all actions undertaken by the provider in relation to the corrective measures required against Health and Disability Services Standard 1.2.8, 2.2.3 (as approved under Section 13 of the Act) must be submitted to HealthCERT by 20 October 2015. The report will inform the Director-General of Health of progress in accordance with the Ministry of Health's requirements. An amended schedule will be issued if progress is not satisfactory.

A written progress report that outlines all actions undertaken by the provider in relation to the corrective measures required against Health and Disability Services Standard 1.2.1, 1.2.3, 1.2.4, 1.3.6 and 1.3.12 (as approved under Section 13 of the Act) must be submitted to HealthCERT by 20 November 2015. The report will inform the Director-General of Health of progress in accordance with the Ministry of Health's requirements. An amended schedule will be issued if progress is not satisfactory.

A written progress reports that outlines all actions undertaken by the provider in relation to the corrective measures required against Health and Disability Services Standard 1.1.8, 1.2.7, 1.2.9, 1.3.4 and 1.3.5 (as approved under Section 13 of the Act) must be submitted to HealthCERT by 20 December 2015. The report will inform the Director-General of Health of progress in accordance with the Ministry of Health's requirements. An amended schedule will be issued if progress is not satisfactory.

A written progress reports that outlines all actions undertaken by the provider in relation to the corrective measures required against Health and Disability Services Standard 1.1.13, (as approved under Section 13 of the Act) must be submitted to HealthCERT by 20 March 2016. The report will inform the Director-General of Health of progress in accordance with the Ministry of Health's requirements. An amended schedule will be issued if progress is not satisfactory.