Inspection Report

Heritage Lifecare Limited – Palms Lifecare

Date of Inspection:

15 August 2018

HealthCERT
Quality Assurance and Safety
Protection Regulation and Assurance
Ministry of Health

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2. Provider details

Certificate:	Three years: 25 August 2017 to 25 August 2020
Premises:	Palms Lifecare
Premises Address:	104 Harris Street
Contact Person:	[redacted]
Inspection Date:	15 August 2018

3. Executive summary

This unannounced inspection was undertaken on 15 August 2018 at Heritage Lifecare Limited – Palms Lifecare (104 Harris Street, Pukekohe).

The inspection was undertaken determine if the services being provided met the relevant Health and Disability Services Standards (2008). The inspection was completed by the Ministry in accordance with sections 40, 41, and 43 of the Act. Two senior registered nurses from Counties Manukau and Auckland/Waitemata DHB's were also on the inspection team.

The focus of the inspection was to consider aspects of the quality and risk framework, and determine whether clinical care was being provided to the required standard following recent complaint activity. The onsite inspection included review of nine resident files, and interviews with 24 staff, seven residents and four family members.

On the basis of the evidence, Heritage Lifecare Limited – Palms Lifecare did not fully comply with ten of the Health and Disability Services Standards (NZS 8134:2008). The partially attained standards relate to: governance, the quality and risk framework, adverse event reporting, human resource management, staffing, assessment, planning, activities, evaluation and the physical environment.

Despite the resulting corrective actions it is important to mention the staff reported being happy at the facility, and the general practitioner was of the view staff were responsive in seeking medical support for residents. Residents and family interviewed were happy with the service being provided.

Ongoing monitoring will be undertaken by the District Health Board.

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

The Western Operations Manager and the Palms Lifecare team provided support to the inspection. The Western Operations Manager had recently moved to Palms Lifecare (the facility) to provide additional oversight to the service.

On the day of the inspection the certified services included 55 (of 59) rest home residents and 54 (of 60) hospital residents (this included one hospital level resident receiving respite care).[1] Services are provided from two separate buildings – rest home and hospital - with hospital services being delivered across two floors.

A Clinical Services Manager (CSM) – registered nurse - appointed July 2018, provided clinical oversight to the rest home and hospital services. At the time of the inspection there were two Unit Coordinators (registered nurses) in post with a third to be recruited. Following appointment of the third Unit Coordinator (UC) there will be two in the hospital, and one in the rest home. The UC's reported they are yet to commence their new roles (link 1.2.8).

The CSM reports to a facility manager (non-clinical), who reports to the Northern Operations Manager (non-clinical).[2] The Operations Manager reports to the Chief Executive. This structure suggests a lack of clinical governance to support and lead clinical practice and staff.[3]

Certified aged residential care services (in particular hospital services) are primarily led by registered nurses, and as such it is reasonable to expect evidence of clinical leadership and governance within an organisations structure.

b) Quality and Risk Management Systems

A comprehensive review of the provider's quality and risk system was not undertaken during the inspection, however it was noted the annual resident satisfaction survey was last completed April 2017 (link to 1.3.7).

There are a suite of policies to support staff, an internal audit programme with corrective action statements, and clinical indicator monitoring, it is the view of the inspection team that there are opportunities for improvement within the quality and risk system, examples are outlined below:

a) During the course of the inspection the policy; Wounds – Assessment and Management (6L2) was reviewed. The policy reports care givers complete wound care in 'an emergency in the absence of an RN' and that caregivers who are 'assessing minor wounds' must get input from an RN. The policy is unclear on the severity of wound a care giver can manage

b) The internal audit programme,[4] includes aspects of clinical care such as wound care, pain management and continence. These audits were scheduled at six monthly intervals.[5] There may be benefit in having an internal audit programme that is responsive to clinical issues

[1] At the time of the inspection the provider had voluntarily stopped admissions to the facility.
[2] The Northern Operations Manager has a portfolio of six facilities up to Whangarei.
[3] At the time of the inspection, Heritage Lifecare had put additional clinical support into Palms Lifecare.
[4] A significant number of internal audits were programmed across the calendar year.

c) The clinical indicator programme did not appear to be well understood in terms of reporting requirements – for example where a fall is reported on day 1 for example, and on day 3 bruising appears (which may or may not be related to the fall), it was unclear during the inspection if this bruising is reported (link 1.2.4).

Heritage Lifecare report a quality role dedicated to the facility (20 hour/week) is to be appointed. It is expected aspects such as (but not limited to) those outlined above, will be considered ensuring a robust system is in place to measure and monitor clinical outcomes. The Ministry will request that Heritage Lifecare's designated auditing agency report progress on strengthening the quality and risk system at the next unannounced surveillance audit of the facility.

c) Adverse Event Reporting

Staff interviewed informed resident incidents are reported on an incident form. The completed form goes via the UC to the CSM for formal reporting. The completed form is then filed in the residents file.

There were instances where incident forms on the residents file had not been signed as completed (verified during interview) and there was a suggestion that under-reporting of resident incidents may be inadvertently occurring (interview) – also refer above *Quality and Risk Management Systems*.

d) Human Resource Management

An audit against all aspects of standard 1.2.7 (Human Resource Management) was not undertaken as part of this inspection.

Seven staff files were reviewed and there was evidence sufficient recruitment processes had been undertaken. Training had been provided to staff, although interviews reported a perceived lack of support for completion of CareerForce training. In an attempt to strengthen training opportunities for registered staff there is an intent to link to the district health board PDRP programme. There were completed competency assessments on file.

While caregivers reported a three day orientation programme, evidence of completed orientation was variable in the files reviewed. It was suggested there may be benefit in individualising orientation programmes for new staff based on their experience (etc). There was no evidence on file of orientation for the new senior roles (CSM and UC) – acknowledging they are relatively new into these roles.

Current appraisals were not evident on three of the files reviewed. Interview verified the appraisal process has been delayed.

e) Service Provider Availability

On the day of the inspection it was noted Heritage Lifecare has been responsive in providing clinical support to the facility including the presence of the Western Operations Manager, the planned part-time availability of a clinical lead from another Heritage facility, and two registered nurses (RN) from Christchurch to support RN vacancies.

At an operational level the CSM is in post (appointed July) and two of three UC's have

[5] The process of re-audit where an outcome does not meet a prescribed threshold was not fully explored

now been appointed (a third is being recruited). The RN vacancies are being backfilled. Admissions to the facility have been stopped, and to their credit, the caregiver hours have been increased recently in the hospital units.

While the service may meet rostering requirements the facility has experienced a number of recent changes with staffing, and at the time of the inspection there continues to be a fragile workforce. Stabilising the workforce is seen as a priority.

f) Assessment

The inspection team reviewed nine rest home resident files and five hospital resident files. The main areas for improvement against this standard were:

- pain assessments were not consistently completed (hospital) and there was inconsistent monitoring (hospital) and/or follow-up of pain issues (rest home)
- there was no clear assessment for the type of incontinence product reported (hospital).

g) Planning

Review of the clinical files identified:

- care plans had not been individualised to the level that would be expected to provide care (three of five hospital files)
- interventions reported in the care plan did not reflect the goal of weight gain, and there was no evidence of referral to a dietician (hospital)
- challenging behaviour was not reported in the long term care plan (hospital)
- family (or residents) are not signing care plans (hospital)
- no apparent consideration of prevention strategies for frequent faller/s (rest home) (link 1.2.4)

The facility acknowledged an awareness of these issues and discussed a planned approach to review (and update) all resident care plans.

In terms of clinical records the inspection team noted there may be benefit in reorganising clinical files. Consideration should be given to entries made by night shift staff as there appeared to be limited entries made (hospital). It is assumed these aspects will be considered as the planned review is undertaken.

h) Planned Activities

Feedback from the 2017 resident survey reported 66% satisfaction with ‘recreation’. During the inspection there were long periods of time on one hospital floor where there was no activity programme observed, and staff interview confirmed the diversional therapist working in the hospital works a half day on each floor. The rest home activity programme was seen to be offered in the morning only.

Based on observation and noting the feedback from the 2017 resident survey, a review of the activity programme – including staffing is required.

i) Evaluation

Evaluation of resident goals, and short term care planning (STCP) processes require attention:

- Evaluation of long term care plans are not always being completed (rest home), and where an evaluation has occurred this has been reported a 'few days' after writing the care plan (hospital)
- When goals are evaluated, interventions are not consistently updated into the intervention section of the care plan (hospital)
- STCPs were not evidenced for short terms issues such as; challenging behaviour (hospital), swollen knee (hospital)

j) Facility Specification

In the rest home, wall heaters had recently been installed. On the day of the inspection these were operating and were hot to the touch. A method to ensure residents do not incur injury is required.

5. Inspection team

The inspection was undertaken by [redacted], Principal Advisor, and [redacted], Senior Advisor, HealthCERT, Ministry of Health, under delegated authority of the Director-General of Health. [redacted] Clinical Speciality Nurse, Adult Rehabilitation and Health of Older People, Counties Manukau DHB, and [redacted] Quality Nurse Leader, Health of Older People, Auckland and Waitemata DHBs also attended.

6. Inspection process

The following methodology was used during the inspection:

- interview with staff
- physical tour of the premise
- review of clinical record
- review of relevant policies and procedures.

7. Inspection limitations

The scope of the inspection was primarily limited to the quality and risk management system and clinical care of residents. Other aspects have been considered where resident outcomes may be impacted.

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 timeframe
Standard 1.2.1 The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	The structure suggests a lack of clinical leadership and governance to support Palms Lifecare.	Develop a structure that evidences the availability of clinical governance for Palms Lifecare.	PA Mod 180 days
Standard 1.2.3 The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	The annual resident satisfaction survey was completed in April 2017.	Complete a resident survey and develop a corrective action plan to address issues raised.	PA Low 180 days
Standard 1.2.4 All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/ whanau of choice in an open manner.	There were instances where incident forms on the residents file had not been signed as completed and suggestion that under-reporting of resident incidents may be inadvertently occurring.	Ensure all reported incidents have been reviewed and signed as completed. Clarify expectation of reporting requirements.	PA Mod 90 days
Standard 1.2.7 Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	There was inconsistent evidence of completed orientation in staff files reviewed. Annual staff appraisals were overdue.	Appointed staff complete an orientation suitable to meet the needs of their role. Appraisals are scheduled and completed annually.	PA Moderate 90 days
Standard 1.2.8 Consumers receive timely, appropriate, and safe service from suitably qualified/ skilled and/or experienced service providers.	A third UC is to be appointed. RN vacancies are being backfilled by temporary staff.	Continue recruitment plan to stabilise workforce.	PA Moderate 90 days
Standard 1.3.4 Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	Of the resident files reviewed it was noted: (i) pain assessments were not consistently completed, there was inconsistent monitoring and/or follow-up of pain issues (ii) there was no clear assessment for the type of incontinence product reported	Ensure pain assessments and ongoing monitoring is reported. Continence assessments are completed that include the type appropriate product for resident use	PA Moderate 60 days
Standard 1.3.5 Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	Review of the clinical files identified the following aspects requiring attention: (i) care plans were not always individualised (ii) interventions reported in the care plan did not reflect the goal of weight gain, and there was no evidence of referral to a dietician (iii) challenging behaviour was not	Resident plans of care are individualised to reflect their needs	PA Moderate 60 days

Relevant Standard	Findings	Required Corrective Action	Rating and timeframe
	reported in the long term care plan (iv) family (or residents) are not signing care plans (v) no apparent consideration of prevention strategies for frequent faller/s		
Standard 1.3.7 Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	There were periods of time on one hospital floor where there was no activity programme observed. The rest home activity programme was offered in the morning only.	Ensure an activities programme is offered reflecting ordinary patterns of life and to maintain resident strengths.	PA Low 180 days
Standard 1.3.8 Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	Evaluation of long term care plans are not always completed, and where an evaluation occurred this had been reported a 'few days' after writing the care plan. When goals were evaluated, interventions are not consistently updated into the intervention section of the care plan (hospital). STCPs were not evidenced for short terms issues such as; challenging behaviour (hospital), swollen knee (hospital)	Long term care plans are evaluation at a frequency that enables regular monitoring. STCP's are used to monitor short term issues.	PA Moderate 60 days
Standard 1.4.2 Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	In the rest home, wall heaters have recently been installed. On the day of the inspection these were operating and were hot to the touch.	The heaters have a guard installed to ensure the risk to residents is mitigated	PA Moderate 30 days

9. Meeting at the end of the inspection

The closing meeting was attended by members of the Palms Lifecare team, the inspection team and the District Health Board Health of Older Persons Portfolio Manager. On the telephone [redacted], CEO and [redacted] Clinical Quality Improvement Lead.

[redacted] thanked the team for their participation and approach to the inspection, recognising that this was an unannounced inspection. It was explained that a draft report will include a full description of findings. The draft report will be sent to the provider within 20 working days for correction of errors.

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. Heritage Palms 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 1.4.2 must be submitted to the district health board within 30 days. HealthCERT will notify the Director-General of Health of progress, if any, and if required in accordance with the Ministry of Health's requirements for the processing of progress reports.

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 1.3.4, 1.3.5, 1.3.8 (as approved under Section 13 of the Act) must be submitted to district health board by within 60 days. HealthCERT will notify the Director-General of Health of progress, if any, and if required in accordance with the Ministry of Health's requirements for the processing of progress reports.

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 1.2.4, 1.2.7, 1.2.8 (as approved under Section 13 of the Act) must be submitted to district health board within 90 days. HealthCERT will notify the Director-General of Health of progress, if any, and if required in accordance with the Ministry of Health's requirements for the processing of progress reports.

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 1.2.1, 1.2.3, 1.3.7 (as approved under Section 13 of the Act) must be submitted to district health board within 180 days. HealthCERT will notify the Director-General of Health of progress, if any, and if required in accordance with the Ministry of Health's requirements for the processing of progress reports.