Funder: Residential Care
Proactive Release: 18 April 2019

09 April 2019

[redacted]

E-mail: [redacted]

Dear [redacted]

Official Information Act (1982) Request

I write in response to your Official Information Act request dated 07 March 2019. You requested the following information:

The information sought in this request is to be used as part of a report by the New Zealand Herald into aged care.

- **Since January 1 2018, copies of any reports, documents, memoranda, and correspondence related to DHB investigations or action related to alleged substandard care or care issues at the Palms Lifecare and Village.**
- **Since January 1 2018, copies of any reports, documents, memoranda, and correspondence related to corrective action or changes at the Palms Lifecare and Village.**

We contacted you on 13 March to discuss your request, and advised that the scope of material was significant, and could take some time to collate, as well as consider under the Act the privacy and commercial impacts of some elements of the information sought. In doing so, we noted that:

> *"Over the last year, CMDHB has worked very closely with this facility, and also with the Ministry of Health - Healthcert team, to address the issues raised in 2018. This has included numerous site visits, improvement plans, and checks along with related correspondence with all parties".*

We asked that you consider a narrower scope of inquiry, and a more accurate description of the output being sought from the DHB, given that the DHB responsibility is to oversee that progress is occurring on the required issues, however the facility is responsible for implementing and providing evidence of changes made.

We offered to provide you with a timeline summary of the key actions that the DHB has undertaken in the last year, and access to copies of the key reports (the Healthcert Inspection Report, and the most recent Progress report against the Corrective Action Plans), along with copies of formal letters sent to the facility.

You advised us on 13 March that you were agreeable to this proposed refinement, and noted that:

Previously I reported about the case where the elderly man was found with maggots in his wounds. However, I understand there have been other complaints relating to other residents, and the DHB may have investigated these, resulting in reports and corrective actions.

- **Can the refinement please capture these cases too?**

I also understand there may have been some issues with getting Heritage LifeCare/ the facility to progress corrective actions, or do so quickly enough.

- **Can the request please cover any correspondence or memos related to this problem (if it has in fact occurred)? If there is a large amount of documentation around this aspect, I'm only after summary correspondence or documentation, if that makes sense.**

Please find (***attached***) material related to your request.

As we noted in our clarification, there has been a significant amount of documentation, visits and material created in dealing with this matter over the last year. Consequently, we are providing a Summary of the DHB action over the last twelve months with this Facility, including anonymised details of three further / related complaints investigated by the DHB.

We have advised all the parties involved in these matters of this request, and sought their views on release of the information. We sought the views of the families involved in placing the formal complaints, and they have agreed to us providing anonymised summary details related to each of their complaints, and the DHB investigation findings.

We are aware that you have previously received a complete copy of the Investigation Report, related to the initial complainant (in March 2018), and that we provided information to you on earlier Residential Care Complaint Investigations by the DHB in an Official Information Act response in May 2018.

Copies of the report of the Unannounced Inspection that Healthcert completed in August are publicly available on the Ministry of Health website, along with the progress on the agreed Corrective Action Plan (including action and sign off dates).

- Link: https://www.health.govt.nz/your-health/certified-providers/aged-care/palms-lifecare

Also included (***attached***) is a copy of the letter sent by CMDHB to Heritage Chief Executive by the DHB HOP Programme Manager in July 2017, along with the response the DHB received from Heritage LifeCare. We have withheld some details of the information in our letter.

As noted in the letter, during a site visit in June 2018, observations were made by the HOP Programme Manager and Clinical Nurse Specialist, which were not directly related to the existing complainants, with whom we retain contacts with, and can sought views on release of information. We have considered our obligations to the public interest in this withheld material, while balancing the privacy interests of the individuals affected. The letter used observed examples of issues of

concern from a site visit in June. The withheld details in the CMDHB letter relate to other Palm's LifeCare residents at the time of the visit, and include details that make these residents identifiable. As such, we believe their right to privacy outweighs the public interest in this matter. We do this under Section 9(2)(a) – protect the privacy of natural persons.

We believe the public interest is best served in knowing that quality standards for all Aged Related Residential Care facilities in our region are actively monitored, and improvement expected, rather than providing the specific examples of observations of individuals that were used by the DHB team to progress this with the facility.

As outlined in the timeline summary, since concerns were first raised, the DHB has continued to work hard with facility staff, managers and the Heritage Board to identify address and remediate all issues, and followed up when progress was seen to be slow. We are satisfied with the progress made since last year.

I trust this information satisfactorily answers your query. Please contact us in the first instance to discuss any questions arising from the summary provided or to seek other material. If you are not satisfied with this response you are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act.

Please note that this response or an edited version of this may be published on the Counties Manukau DHB website.

Yours sincerely,

Fepulea'i Margie Apa
Chief Executive

OIA 13032019 JONES - Palms LifeCare
Appendix 1

Background to Initial Complaint and Investigation

8 March 2018: CMDHB Health of Older People Programme Manager (HOP PM) was alerted to a complaint about care at Palms LifeCare, Pukekohe, following a RadioLive interview with the daughter of Resident. A CMDHB Community Geriatric Service Clinical Speciality Nurse (CNS) was asked to visit the facility immediately to assess the resident, which she did in conjunction with one of the facility General Practitioners.

The CNS recorded the family's complaint, and relayed this to the CMDHB HOP Programme Manager.

The HOP Programme Manager visited the facility in the afternoon of 8 March 2018 to get a better understanding of the issue, and arranged to meet the national Quality Manager the following morning. The HOP Programme Manager alerted the Healthcert and DHB Management teams to the complaint.

9 March 2018: Resident EB died in the early hours of the morning.
9 March 2018: HOP Programme Manager met with the Heritage and Palms management teams. They advised that they had completed an initial review and confirmed they had identified gaps in Resident's care, primarily pain management, communication and basic hygiene.

12 March 2018: HOP Programme Manager spoke with Heritage QM who advised that an experienced RN was being seconded to the facility. HOP Programme Manager advised that she and the CMDHB HOP Clinical Speciality Nurse (CSN) would carry out a site visit the following day to commence an investigation. CSN works with the HOP funder team to support complaint investigation, audit and monitoring.

Complaint formally logged in CMDHB Feedback system, and facility advised of investigation.

13 March 2018: HOP Programme Manager and CSN carried out a site visit, and commenced complaint investigation.

Heritage confirmed that they were carrying out a review of all residents (starting with those with high interRAI CHESS scores – a measure of clinical stability). A Heritage national Quality Manager confirmed she was working full time at the facility to ensure all residents were assessed, and to identify and address any quality issues. HOP Programme Manager offered support from the DHB Community Geriatric Service if complex clinical issues were identified.

20-22 March 2018: Heritage Investigation Report and CMDHB Investigation reports were finalised and provided to Heritage, CMDHB and Healthcert.

- **CMDHB and Heritage Investigation Reports – Provided to the family (who shared that report with NZ Herald in 2018).**

Related matter: Ministry of Health Healthcert, CMDHB HOP Programme Manager and Clinical Nurse Specialist meet with Resident EB family in May 2018. During this meeting, the family noted an additional concern related to management of their relative's beard, alleging it was shaved without his consent in the month prior to his death. The investigation substantiated that had occurred, with limited documented evidence of consultation for consent from the resident. The review substantiated that there was limited guidance in the Lifestyle Plan around the

management of his beard, despite opportunities to do this in in terms of his hygiene, personal grooming, and expression of sexuality care planning.

Summary of the three other Complaints lodged during 2018, also all managed in accordance with the CMDHB Residential Care Complaints processes.

Regarding Palms LifeCare, and as a direct result of the March 2018 media exposure:

Complaint One: HOP Programme Manager was contacted by the family of a resident, raising concerns about care provided in early 2018, and the response they got to their complaint later that month from the then-current Palms Clinical Services Manager (CSM). CMDHB Investigation Report was finalised on 25 April 2018.

Findings:

The CMDHB Investigation Report substantiated the allegation that rthe Resident's condition was not managed in accordance with post-falls protocols for an 8 hour period over night following a fall in early January 2018. This meant that the injuries were not identified until the following morning. The Investigation also substantiated some aspects of the Yellow Envelope component of the complaint (acute hospital transfer process). However, the issues were related to the Palm's documentation processes, rather than the requirement to provide the relevant documentation. The Investigation substantiated that the Facility did not complete assessments and care plans within the timeframes required under the ARRC Agreement.

When the Resident's family lodged a complaint with the Palm's CSM, that investigation did not fully investigate the issues, and there was lack of open disclosure to the Resident's family following the complaint about the care. A meeting between the Heritage interim Chief Executive and National Quality Manager, and the complainants was facilitated by HOP Programme Manager.

Complaint Two: HOP Programme Manager was contacted by the family of a resident, raising concerns about care provided in mid-2017. These concerns had been raised with the previous CSM, although the family were unaware if this had been formally logged as a complaint by Palms. The CMDHB Investigation Report was finalised on 24 April 2018.

Findings:

The CMDHB Investigation Report substantiated that mandatory assessment and care planning was not completed in a timely fashion and a Pressure Injury was not managed to best practice standards. Over two days in mid-2017, there was a delay in recognising the Resident's fractures, which meant a delay in accessing appropriate treatment. Over this period, pain was not well managed, lacking comprehensive and coordinated assessment and care planning to identify and address the pain.

The GP and family raised concerns with the CSM and Facility Manager. However, the Palms management team did not recognise the family and GP concerns as a complaint, and did not follow this up. An investigation would have identified the issues earlier, and prevented escalation in March 2018.

Complaint Three: A complaint was lodged by family of a resident regarding care at Palms LifeCare, as a direct result of the Call Bell Outage (June 2018).

As a result of the call bell outage at Palms, HOP Programme Manager was contacted by the family of a resident, raising concerns about care provided in the immediate past, prior to an admission to Middlemore in early July 2018. Concern was raised that care was adversely impacted by the call bell outage, with the Resident being unable to alert staff if condition deteriorated. CMDHB Investigation Report was finalised on 13 August 2018.

Findings:
The CMDHB Investigation Report substantiated that there were gaps in assessment and care planning which were exacerbated by the call bell outage, leading to the Resident receiving less than optimal care.

It was noted in the Investigation Report that the identified issues closely reflected the substantiated issues from other complainants about care at Palms LifeCare.

While there was a Corrective Action Plan in place to address the previously identified issues, the outcome of Complaint Three indicated that Corrective Action Plan work to date had not been effective in addressing these issues. The Investigation Report noted that this issue would be raised directly with the Heritage Board to ensure the issues were comprehensively understood and addressed.

CMDHB Corrective Action Plan Monitoring:

A Corrective Action Plan (CAP) is a tool, which outlines the requirements for quality improvement through a step-by-step process, and supports monitoring and verification of the work completed.

The Palms CAP used the Heritage LifeCare CAP template, and included a description of the issues identified requiring Corrective Actions, the Corrective Action required, the person responsible for the Corrective Action, timeframe and an evaluation/monitoring section. It also contained an option for Narrative comment of progress. CMDHB added a section for DHB comment and feedback.

Between 8 March 2018 and 8 August 2018, members of the CMDHB HOP team carried out twelve (12) site visits to Palms LifeCare.

The work undertaken at these site visits included:

- Strategic and Progress meetings with Heritage and Palms management
- Monitoring via documentation reviews (including using tracer methodology)
- Staff, resident and family interviews
- Observation of work in action.

Additional actions occurred as an outcome of the site visits including, but are not limited to, meetings and phone calls with Heritage and Palms management, monitoring via email updates, referral to other DHB services such as the CMDHB Professional Development Recognition Programme (PDRP), HOP Clinical Nurse Director, and CMDHB Education sessions.

The Ministry of Health - Healthcert and CMDHB management teams were updated regularly and provided with advice as required.

Key CAP progress monitoring steps included:

22 March 2018: Initial Complaint recommendations were discussed with Heritage and Palms LifeCare teams and the CAP finalised.

11 April 2018:
Notification that previous CSM no longer works for Heritage, and the Heritage Quality Lead, has been appointed as interim CSM.

24 April 2018: Complaint One - recommendations were discussed with Heritage and Palms LifeCare teams and CAP was finalised.

24 April 2018: Complaint Two - recommendations were discussed with Heritage and Palms LifeCare teams and CAP was finalised.

9 May 2018: CMDHB HOP Programme Manager, CSN, and HOP Clinical Nurse Director met with the Heritage and Palms LifeCare team to discuss the CAP process.

As an outcome, all CAPs were consolidated into a single facility CAP. Overall timeframes were discussed with a goal for complete sign-out toward the end of 2018, to ensure any actions were embedded and sustainable.

As part of the monitoring and verification process for progress Palms LifeCare was required to submit an updated CAP to Heritage, for the Heritage monthly Board meetings, send the updated CAP to CMDHB at the same time, and also contact CMDHB as required outside that timeframe. The CMDHB CSN would visit the facility following receipt of the monthly CAP, to monitor progress as per the usual CMDHB monitoring process. Following this meeting, the next updated CAP was anticipated toward the end of May 2018.

At this time, Heritage advised that the Palms Management team was being reconfigured - with the addition of three Unit Coordinators and 18 hours/fortnight of Quality Coordinator, with the Registered Nursing roster to remain the same. There was active recruitment underway for a CSM and the Unit Coordinators, and the interim CSM would remain in the role until a permanent CSM was appointed.

CMDHB provided a considerable amount of information about training opportunities, and confirmed attendance of the RNs at both the CM Health Wound Coach forum, and Age Related Residential Care Training Days. The CMDHB PDRP Coordinator was due to visit the facility on 16 May 2018, with a plan to enrol all Palms LifeCare RNs in the CMDHB PDRP programme.

28 May 2018: Notification to CMDHB and Healthcert of appointment of a temporary CSM, who had been appointed as a Unit Coordinator, and seconded in to the position of CSM while Heritage continue to recruit a permanent CSM.

31 May 2018: Palms LifeCare submitted the consolidated CAP to CMDHB with an outline of work to date.

14 June 2018: Site visit by HOP Programme Manager and Clinical Nurse Specialist. The intent of the visit was to get a high-level understanding of the current situation and progress since the consolidated CAP was developed. Randomly selected resident files were reviewed, using tracer methodology, staff members were interviewed and care was observed.

The outcome of this monitoring site visit was a finding that, although there was evidence that remedial actions were being implemented, there was still considerable amount of work to be completed and embedded into practice.

20 June 2018: Heritage advised HOP Programme Manager of a significant resident call-bell outage, as a result of a lightning strike at the facility. Heritage advised that components of the call-bells were damaged, and Palms LifeCare had implemented their Call-Bell Outage Management Plan, while a repair plan was implemented. This included rostering additional staff, completing intentional rounding (focussed checking on every resident every 30 minutes), locating the staff in positions around the facility to enable them to monitor the call-lights, which were still working, encouraging residents to be in lounge areas, and keeping room doors open.

26 June 2018: HOP Programme Manager carried out an unannounced visit to the visit to observe the Call Bell Outage Management Plan in action.

HOP Programme Manager identified gaps in the plan around as the call lights were also out of action in some areas, there was little signage to advise visitors of the call bell outage and handbells/ alternative alert mechanisms were not consistently provided to residents.

The Facility Manager was asked to update and monitor the implementation of the Call Bell Outage Management Plan, and include daily monitoring of the call lights. The Facility Manager provided a regular update, until the call bell system was fully replaced with a pager system on 11 July 2018.

3 July 2018: Palms LifeCare submitted the updated consolidated CAP to CMDHB, with an outline of work to date.

6 July 2018: As a result of the call bell outage at Palms, HOP Programme Manager was contacted by the family of a resident, raising concerns about care provided in the immediate past, prior to an admission to Middlemore in early July 2018. (***See notes related to Complaint three above***).

11 July 2018: An unannounced site visit was completed by HOP Programme Manager and CSN. The intent of the visit was to review the CAP work to date, review the Call Bell Outage Plan, and verify that CAP Corrective Actions were being implemented and embedded. Targeted resident files were reviewed using tracer methodology, and staff members and a family member were interviewed.

The visit noted that at that time it appeared the previous education and monitoring had not yet been sustainably embedded into ongoing practice. A number of recommendations were made to Heritage and Palms teams, both at the visit exit meeting, and via email to the Heritage team. It was noted that the Palms Corrective Action Plan entry (12 May 2018 and 25 May 2018) had both indicated that there was high compliance in clinical documentation, but evidence of this was needed. It was strongly recommended that there was ongoing audit of the Progress Note documentation, to ensure that the education completed on clinical record documentation was embedded into practice. It was recommended that the Lifestyle Plans reviewed during the site-visit were further reviewed to ensure the plan accurately reflected all needs.

Continued close monitoring by Heritage LifeCare was recommended to ensure that local improvements were managed within the Heritage LifeCare policy requirements.

23 July 2018: Notification to CMDHB and Ministry of Health, Healthcert of appointment of a permanent CSM, being confirmation of the previously temporary CSM appointee.

27 July 2018: The HOP Programme Manager précised all DHB information in narrative format, as the DHB had entered a large amount of information into the Corrective Action Plan, covering monitoring visits, and the additional Call Bell outage. This format was sent with a letter to the Heritage interim Chief Executive, with a request for feedback from the Heritage Board

Letter sent to Heritage Board by CMDHB Programme Manager (***attached***)**.**

The letter indicates that concerns remained about the implementation, embedding and monitoring of the Corrective Actions, with DHB monitoring still reflecting issues similar to those s identified in the earlier complaints. It was noted there were a number of episodes where the CAP indicated work had been done, but evidence to confirm this was lacking.

1 August 2018: Heritage interim Chief Executive responded to CMDHB Letter – outlining changes in clinical leadership and governance (***attached***).

8 August 2018: CMDHB HOP Programme Manager, Clinical Nurse Specialist, and the MoH Healthcert team met with the Heritage Chief Executive and Ops Manager, to discuss the slow progress with implementing the CAP actions. The Heritage Ops Manager had commenced in the new oversight role on 6 August 2018.

14 August 2018: HOP Programme Manager received feedback by email from Heritage Ops Manager advising of staff and roster changes to support clinical reviews of all resident. HOP Programme Manager provided pre-inspection comments/input to Healthcert on potential outcomes of the unannounced inspection to be held by HealthCert the following day.

15 August 2018: MoH Healthcert completes an Unannounced Inspection.
HOP Programme Manager notified CMDHB management team on the commencement of the MoH Healthcert Unannounced Inspection at Palms LifeCare, and provided background to the decision by Ministry of Health to carry out the Unannounced Inspection.

15 August 2018: HOP Programme Manager updated the CMDHB management team with feedback from the Inspection Exit Meeting. The issues identified throughout the Inspection of the hospital unit were consistent with the identified CAP issues, but there did appear to be some evidence of improvement. Key gaps remained evident in wound, continence and pain management.

20 August 2018: HOP Programme Manager requested meeting with Heritage Chief Executive and Palms Ops Manager on 27 August 2018. Details of specific clinical issues identified during the inspection were provided for clinical follow-up.

27 August 2018: HOP Programme Manager meeting with Heritage Chief Executive and Palms Ops Manager. Overview of meeting – agreement was to discontinue the "established" CAP, and await the new Inspection Report CAP, that would include all remaining actions, but in the interim work would continue, and this would be reflected in the new CAP when it was developed.

11 September 2018: Unannounced Inspection Report findings were in line with the issues the DHB had identified following a number of complaints regarding the facility since February 2018.
The Inspection Audit process was noted to be valuable as a building block in assisting the facility to focus and build on improvements, while also implementing best practice across both the Hospital and Rest home.

21 September 2018: HOP Programme Manager meeting with Ops Manager. Heritage advised they had commenced development of the new CAP, aligned to the findings of the 15 August 2018 inspection. It was agreed that CMDHB would formally commence the review process for the Unannounced Inspection Report CAP when the final report was published.

24 September 2018: Final report published (***publicly available on the Ministry of Health website***) – and the revised CAP sent to Palms, with first criterion due for completion by 14 October 2018.

02 October 2018: Request from Heritage for a staged/ monitored admissions process at Rest Home level care over the following three weeks. This is to test a new electronic admission process. Three agreed admissions monitored – no issues identified with processes.

16 October 2018: HOP Programme Manager meeting with Ops Manager provided a general update regarding progress.

17 October 2018: Following discussion with Healthcert and Ops Manager, approval was given to start resident admissions at one/two a week.

24 October 2018: CSN monitoring visit – sign out CAP [Standard 1.4.2: Facility Specifications (heaters)].

30 November 2018: CSN monitoring visit – sign out CAPs 1.3.4, 1.3.5 and 1.3.8 based on the CSN assessment on the day.

12 December 2018: CSN monitoring visit – sign out CAPs 1.2.4, 1.2.7 and 1.2.8 based on the CSN assessment on the day.

14 January 2019: HOP Programme Manager and Facility Manager update meeting

29 January 2019: HOP Programme Manager and Heritage Ops Manager update meeting

8 February 2019: Notification to CMDHB and MoH Healthcert of a new temporary Facility Manager, who is appointed as Facility Manager while Heritage continues to recruit a permanent CSM.

12 February 2019: Introductory meeting between HOP Programme Manager and temporary Facility Manager.

15 February 2019: Notification to CMDHB and Healthcert of a permanent Facility Manager, who has been the temporary Facility Manager for a short period of time.

18 March 2019: CSN monitoring visit – sign out CAPs 1.2.1, 1.2.3 and 1.3.7 based on the CSN assessment on the day.

19 March 2019: Pre-audit feedback provided to Designated Auditing Agency to review all CAP during the upcoming Unannounced Inspection, to ascertain the progress the facility has made toward embedding the corrective actions.

Upcoming Events: An Unannounced Surveillance Audit by the Designated Audit Agency (DAA), on behalf of the Ministry of Health Healthcert Certification programme for all NZ Aged Related Residential Care facilities is scheduled for the coming month. This will be used to confirm the completion as signed out by the DHB monitoring team, and monitor ongoing embedding of all CAP. This surveillance audit is also anticipated to reset the Corrective Action Plan, for monitoring improvement.

CMDHB has committed to continue to monitor the ongoing implementation and embedding of changes. The Clinical and Facility Managers are committed to ongoing responsibility to ensure all criteria are implemented, meet the contractual requirements, and are monitored and sustainable.

The Heritage Palms LifeCare facility has a three-year Certification, with the next full certification audit due in mid-2020, with the current Certification due to expire in August 2020.

OIA 13032019 JONES - PALMS LifeCare
Appendix 2
Withheld content Section 9(2)(a)

27 July 2018

[redacted]
Chief Executive
Heritage Lifecare Ltd

[redacted]

Dear [redacted]

As you will be aware CM Health is monitoring the Corrective Actions undertaken at Palms Lifecare. We are adding the DHB monitoring comments to the Palms Lifecare Corrective Action Plan which Palms Lifecare submits to the Heritage Lifecare board on a monthly basis.

Because the DHB has entered a large amount of information into the current Corrective Action Plan covering monitoring visits and the Call Bell outage I have précised the DHB information for clarification.

We remain concerned about the implementation, embedding and monitoring of the Corrective Actions at Palms Lifecare. The findings of the DHB monitoring still reflect the same issues identified in the [redacted] complaints in terms of issues with assessment, care planning and documentation.

[redacted] CM Health Clinical Speciality Nurse and I carried out an unannounced visit on 11 July 2018. The intent of the visit was use a tracer methodology approach to review work undertaken as discussed at the close out meeting following our 14 June 2018 visit (as noted in the June Corrective Action Plan) and to assess the Short Term Care Plan (STCP) [redacted]. We also planned to interview a visitor and resident if possible.

[redacted] During our visit to Palms Lifecare on 14 June 2018 [redacted] and I reviewed the randomly selected clinical file for [redacted] resident and identified a number of areas for improvement which we discussed with the Palms management team at the close out meeting. [redacted]

[redacted]

[redacted]

[redacted]

I visited Palms Lifecare on 26 June 2018, and discussed the call bell outage management plan with the Facility Manager. She advised that, while the call bells themselves were out of order, the lights outside the rooms were working. A key component of the management plan involved staff positioned around the facility to respond to the lights. I asked to be shown the plan in action, and identified that the majority of the call bell lights tested were not working. [redacted] The intent of the 11 July 2018 review was to see how communication was reflected in the STCP due to the call bell outage.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

The Corrective Action recommendations include closer monitoring and evaluation of implementation of the Corrective Action Plan and review of the Care Plans and STCP for the three residents concerned, and will be reviewed at our next monitoring visit.

We would appreciate feedback from the Heritage Board about the implementations of the Corrective Actions to date.

Yours sincerely

[redacted]

[redacted]
Programme Manager Health of Older People

cc [redacted], National Manager Clinical and Quality, Heritage Lifecare
[redacted], Group Manager Quality Assurance and Safety, Ministry of Health

[redacted]
Programme Manager Health of Older People
Counties Manukau District Health Board

HERITAGE LIFECARE®

[redacted]

Thank you for your letter of 27 July 2018 in which you expressed your concerns in relation to embedding Corrective Actions at Palms Lifecare.

We have carefully considered the points that you raised. We were disappointed to read of your findings related to assessment, care planning and documentation identified during your recent clinical audit at Palms Lifecare. The issues you identified are not consistent with the standards we expect and require for our residents, and we share your concerns.

As you are aware, Palms Lifecare is currently implementing a comprehensive action plan (CAP) in response to a range of identified issues. As has been discussed with your previously, we anticipated that embedding the necessary cultural and practice changes would take some months. At the time that we began implementing the CAP, one of the biggest challenges we faced related to clinical oversight of our care delivery staff. We have since employed a Clinical Services Manager and two Unit Coordinators to provide that oversight. The Unit Coordinators only commenced in their roles on the 23rd of July. To date they have obviously had only limited opportunities to guide service delivery, especially in relation to care planning and oversight of the day-to-day resident management.

The difficulties we have experienced in recruiting registered nurses have also had an impact on care plan development and review. We have just employed three new RNs, and are currently in negotiation to employ another two RNs in the near future.

After discussions with Palms management, and our quality team, we have decided that all resident care plans will be reviewed as soon as possible, and anticipate that most of these will be completely rewritten. This process will be completed by the 24th of September 2018. To help us achieve that target, we have seconded three senior registered nurses from other Heritage Lifecare facilities, who will help backfill Palms staff so they are able to concentrate on care planning. A senior part-time Palms RN will be offered additional hours for care planning; while Adrianne Allen from the Quality Team will also be working almost exclusively for the next month on care planning support and sign off.

Heritage Lifecare has begun the process of rolling out an electronic care planning system (eCase Care Canvas) across all of its facilities. We have every confidence that this system will address many of the care planning issues previously identified at Palms, and provide greater transparency in relation to almost every aspect of care delivery. This system will "go live" at Palms from Monday 24th of September. Existing residents will move onto the electronic care planning system over the following 5.5 months, as determined by their next interRAI review date. All new residents admitted from the 24th of September will go straight onto Care Canvas.

We will continue to monitor and update you on relation to our progress with the Palms CAP. Please be assured that we are committed to ensuring identified shortfalls are addressed, and that service delivery requirements are met and, where possible, exceeded.

Yours sincerely

[redacted]

Interim CEO