# Muralz Limited

## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Muralz Limited

**Premises audited:** Hillcrest Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 1 December 2016 End date: 1 December 2016

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 16

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Hillcrest provides rest home level care for up to 20 residents. On the day of the audit there were 16 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, management, staff and the general practitioner.

The owner is non-clinical with experience in business, marketing and communications. She is supported by an experienced nurse manager who has been in the role for one year. Residents and the general practitioner interviewed were complimentary of the service.

The service has addressed the two previous findings around reference checks and referral for re-assessments.

This audit identified areas for improvement related to policies, interventions and medication charts.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Communication with residents and families is appropriately managed and recorded. There is a complaint register that is maintained. The service has a documented complaints process and there is evidence of follow up and resolution. The service has responded appropriately to a written complaint investigated by the Health and Disability Commissioner.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Hillcrest Rest Home is implementing a quality and risk management system that supports the provision of clinical care. Quality data is collated for infections, accident/incidents, concerns and complaints. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The nurse manager is responsible for each stage of service provision. The nurse manager assesses and reviews each resident’s needs, outcomes and goals at least six-monthly. Care plans demonstrated service integration and included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The nurse manager and senior caregivers responsible for administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the general practitioner at least three-monthly.

A Monday to Friday activity plan is coordinated and implemented for the residents. The programme includes community visitors, outings and activities that meet the individual and group recreational preferences for the residents.

Residents' food preferences and dietary requirements are identified at admission. All meals and baking are cooked on-site. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines. Dislikes are accommodated.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The building has a current warrant of fitness.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint should this be required. The facility remains restraint-free. Staff receive regular education and training on restraint minimisation.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse has attended external education and coordinates education and training for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 14 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 2 | 1 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints are an agenda item in the monthly staff meeting and the monthly quality and risk management (QRM) meeting. Discussions with residents confirmed that any issues are addressed and that they feel comfortable to discuss any concerns. All staff interviewed were able to describe the process around reporting complaints.  There is a complaint register. There have been two complaints reported since the last audit. The complaints have been investigated with corrective actions identified. The service has responded appropriately to a written complaint investigated by the Health and Disability Commissioner (HDC). A HDC letter was sighted stating that there was no further action to be taken. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Five residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Incidents/accidents forms reviewed include a section to record family notification. All incident forms reviewed indicated family were informed or if family did not wish to be informed. Monthly resident/family meetings are documented as taking place. Monthly newsletters are provided to residents.  Interpreter services are available if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Hillcrest Rest Home provides care for up to 20 rest home level residents. On the day of audit there were 16 rest home residents. This included two residents who were living in the two outside units on the property. At the time of the audit, there were two unusable rooms, one was being used as a family room and the other as an office. One resident is on a long-term chronic health condition contract (and was under the age of 65). There was also one resident on respite on the day of the audit. All other residents were under the ARCC.  Hillcrest Rest Home is owned by Muralz Limited. The owner (non-clinical) has a business background and lives locally. The owner reports she works in consultation with the nurse manager to provide the services. The service has a full-time nurse manager, who has been in the role for one year. They are supported by a senior caregiver who lives on-site and a stable workforce. There is a documented business plan (1 April 2016 to 31 March 2017), with a mission statement, key objectives and risk management plan. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Hillcrest Rest Home is implementing a quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow implementation by staff, however the care planning and pressure injury policies do not meet current best practice.  Quality matters are taken to the monthly QRM meeting and then on to the monthly staff meeting. Staff and QRM meeting minutes demonstrate that key aspects of the quality management system are discussed including audit, complaints, infection control, incidents, training and health and safety. Monthly data is provided around accident/incident reports and infections. The staff meeting minutes provide a record that the in-service training has been delivered and verified during interview with two caregivers.  Resident meetings are held monthly and minutes demonstrate issues raised are followed up. Hillcrest is implementing an internal audit programme and corrective action plans are developed when necessary and the closure of corrective actions were recorded. There is a health and safety and risk management programme in place including policies to guide practice. A senior caregiver is the health and safety representative who is working in consultation with the nurse manager and owner. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The service collects incident and accident data and reports monthly to the staff meeting. Incident forms are completed by staff, the resident is reviewed by the most senior staff member at the time. The form is signed off by the nurse manager. Family notification is recorded on the incident form and in the progress notes. Ten incident forms were reviewed (from January 2016 to date), all have been completed as required (noting the service has a low number of incidents). Two caregivers and the nurse manager interviewed could discuss the incident reporting process. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies to support recruitment practices. The nurse manager’s practising certificate is current. Five staff files were reviewed (one nurse manager, three caregivers and one cook) and all had relevant documentation relating to employment. Performance appraisals were current in all files reviewed. There were documented reference checks for newer staff in the files reviewed. The finding from the previous audit is now met.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented checklists (sighted in files of newly appointed staff). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. There is a first aid trained staff member on-site at all times.  There is an education plan being implemented that includes all required education as part of these standards. An in-service calendar for 2016 exceeded eight hours annually and includes training from a nearby facility. There is evidence that additional in-service opportunities are offered to staff. Interview with caregivers confirm in-service education is provided as part of the staff meetings and/or at another local facility. Caregivers administering medications have completed a competency signed by the nurse manager. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The human resources policy determines staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The caregivers and residents interviewed inform there are sufficient staff on duty at all times. Staffing is as follows; two caregivers in the morning, two caregivers in the afternoon and one at night. The nurse manager works full-time from Monday to Friday. The nurse manager and senior caregiver (who lives on-site) are on call 24/7. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | There are policies and procedures in place for safe medicine management that meet legislative requirements. The RN and senior caregivers who administer medications complete annual medication competencies including insulin administration. The RN has completed syringe driver competency. Annual in-service education on medication is provided. Medications (robotic rolls) are checked on delivery against the medication chart and any discrepancies are fed back to the pharmacy. All medications are stored safely. Standing orders are not used. There were no self-medicating residents on the day of audit. The medication fridge is monitored weekly.  Ten medication charts were reviewed. All medication charts had photo identification, however, not all medication charts had an allergy status documented. The GP reviews the medication charts at least three-monthly. The administration signing sheets reviewed identified medications had been administered as prescribed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals and home baking is prepared and cooked on-site by the cook Monday to Friday. The caregivers cook the weekend meals as instructed by the cook. There is a four-week menu that has been reviewed by a dietitian May 2015. Staff have completed food safety in-service. The cook receives dietary information for new residents and is informed of any changes to resident’s dietary needs. Likes and dislikes are accommodated. Residents interviewed were complimentary about the meals provided.  Meals are prepared in a kitchen adjacent to the dining room and served directly to the residents. Fridge and freezer temperatures are monitored and recorded weekly. End cooked temperatures are taken daily. All perishable goods are date labelled. A cleaning schedule is maintained. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | When a resident's condition alters, the RN initiates a review and if required, GP or nurse specialist consultation. There is documented evidence that family members were notified of any changes to their relative’s health including (but not limited to): accident/incidents, infections, health professional visits, changes in medications and referrals/appointments. Residents interviewed state their expectations are being met. Not all interventions have been documented to meet the resident’s needs.  Adequate dressing supplies were sighted. A wound management chart includes a full wound. A dressing care plan includes dressing type and weekly evaluations or more frequently as required. There were no wounds on the day of audit. Documentation was reviewed for a recently healed wound. There is access to the DHB wound nurse specialist for advice for wound management as required.  Continence products are available. The residents’ files include a urinary continence assessment, bowel management plan and continence products used. |
| Standard 1.3.7: Planned Activities  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. | FA | Currently there is no activity coordinator due to a resignation, however interviews are scheduled and advised a suitable person will be appointed in two weeks time. The caregivers are currently implementing the programme for 12 hours per week (9am to 12 noon) and one-on-one time for those residents who do not wish to join in the group activities.  Activities provided are meaningful and include (but are not limited to): newspaper reading, current affairs, housie, NZ memories, story reading, ball exercises, crafts and quizzes. The service hires a taxi for weekly outings and drives into the community. Individual activities are included in the resident’s activity plan such as library time and shopping.  A resident activity assessment is completed on admission. Each resident has an individual activity plan which is reviewed six-monthly. Recreational preferences are age appropriate and meet the individual needs for aged care. Activities are provided for younger residents (LTCHC) on an individual basis.  The service receives feedback on activities through one-on-one feedback, resident’s meetings and surveys. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans for long-term residents were evaluated by the RN within three weeks of admission and a long-term care plan developed. Care plans had been evaluated six-monthly for three long-term residents. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three-monthly or earlier if required. The short-term care plan had been reviewed and amended for the respite care resident as needed to reflect needs/supports. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the residents’ files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents’ files.  There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service. The file of one long-term resident was reviewed and evidenced changes in care, dependency, weight (1.3.6.1) and continence as documented in the care plan. The GP had reviewed the resident and a referral made for re-assessment to a higher level of care. The previous finding around re-assessments has been addressed. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 17 January 2017.  Environmental improvements include re-insulation of the facility, new curtains in lounge and dining room and new lounge chairs. Bedrooms are re-furbished as they become vacant. There is an ongoing maintenance plan. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator/nurse manager collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is discussed at the quality risk meetings and data is available to all staff including graphs. The service completes monthly and annual comparisons of infection rates for types of infections. Infection control surveillance data is signed off by the GP quarterly. Systems in place are appropriate to the size and complexity of the facility.  There have been no outbreaks. The service notified the DHB with one case of confirmed campylobacter that was related to the local outbreak. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers that meet best practice. The nurse manager is the restraint coordinator. There were no residents using restraints or enablers on the day of audit. Staff receive training around restraint minimisation and managing challenging behaviours (May 2016). Care staff interviewed were able to describe the difference between an enabler and a restraint. Care staff complete restraint questionnaires. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.4  There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents. | PA Low | There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Two policies require updating. | The use of interRAI assessments have not been reflected in the admission and care planning policy. Pressure injury prevention and management policy requires updating to reflect the Ministry of Health guidelines. | Ensure that the utilisation of interRAI assessments are reflected in the admission and care planning policy. Ensure that the pressure injury prevention and management policy is updated to reflect the Ministry of Health guidelines.  90 days |
| Criterion 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. | PA Low | The medication charts met legislative prescribing requirements. All ‘as required’ medications had indications for use. All medication charts had photo identification. Five of ten medication charts identified an allergy status. | Five of ten medication charts did not identify an allergy status. | Ensure medication charts have an allergy status identified on the chart.  30 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain and challenging behaviours. Risk assessment tools are utilised for the assessment of risk with outcomes informing the care plan. The care plan has not been updated to meet the current needs/supports for three long-term residents and one resident under the LTCHC contract. | 1.Three resident’s long-term care plans do not have interventions for: (i) fluctuations in weight and weigh management, (ii) diabetic management for resident on insulin and (iii) new pain management plan as per GP notes.  2. One resident (LTCHC) has no documented interventions, early warning signs and symptoms for a diagnosed mental health condition. The same resident does not have any interventions for a suspected cardiac condition or infection as per GP notes. | Ensure interventions are documented for all changes in health status.  60 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

|  |
| --- |
| No data to display |

End of the report.