

Final Inspection Report

Metlifecare Limited- Coastal Villas

Date of inspection: 14 February 2011

HealthCERT
Provider Regulation
Clinical Leadership Protection and Regulation
Ministry of Health

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File Ref: WME08

Provider: Metlifecare Coastal Villas Limited

Contact Person: Ms XXX XXX, Manager

Premise: Metlifecare Coastal Villas
Spencer Russell Drive
PARAPARAUMU

Executive Summary

History

The provider is currently certified for three years with a certificate due to expire 28 October 2013. The provider is certified for hospital (medical and geriatric) and rest home services.

The last certification audit in September 2010, found no partial attainments.

Previous Recent Complaints:

A complaint to the Health and Disability Commissioner (2008) was substantiated regarding care of a resident.

Nature of Current Complaint:

The Ministry of Health (the Ministry) received an anonymous complaint about the services provided at Metlifecare Coastal Villas Limited. If substantiated, the provider may have been in breach of its obligations under the Health and Disability Services (Safety) Act 2001.

The key concerns communicated related to:

- cleanliness of the facility
- staff orientation/education
- availability and use of equipment to carry out residents care
- food service
- Medication management

Further Information (DHB):

Service Description

Metlifecare Coastal Villas is a 30 bed hospital/rest home that adjoins a village complex of 131 Villas and 50 apartments. There are 27 hospital beds and three swing beds that can accommodate rest home residents.

The occupancy and capacity is outlined below:

Area	Occupied	Capacity
Hospital	29	
Rest Home	1	
Total	30	30

Reasons for the inspection

The purpose of the inspection was to determine whether health care services being provided by Metlifecare Coastal Villas, were being provided in compliance with section 9 of the Health and Disability Services (Safety) Act 2001. That is, a person providing health care services of any kind must do so whilst meeting all relevant standards.

Health and Disability service providers are required under section 9 of the Act to provide services:

- (a) *'while certified by the Director-General to provide health care services of that kind;*
- (b) *while meeting all relevant service standards;*
- (c) *in compliance with any conditions subject to which the person was certified by the Director-General to provide health care services of that kind; and*
- (d) *in compliance with this Act.'*

The inspection team

The inspection was undertaken by XXX XXX, Senior Advisor, HealthCERT and XXX XXX, Senior Advisor, HealthCERT, under the delegated authority of the Director-General of Health.

Methodology

The inspection was conducted to investigate the complaint made to the Ministry that may have resulted from system failures and non-compliance against the Health and Disability Services Standards. Findings are according to the Health and Disability Services Standards NZS8134:2008.

The inspection was conducted using the following methods:

- Interview with Manager
- Interview with Registered Nurse (Clinical Leader)
- Individual staff interviews
- Relative/ Resident interviews
- Observation: During facility tours and casual observation of the facility
- Observation: Residents and Staff
- Document and policy review: See the appendix for a list of documents that were requested as part of the audit process.
- Clinical Notes review: A sample of residents' notes from the facility was audited.

Limitations

The scope of the inspection was limited to the issues raised in the complaint.

Entry Meeting

Present: XXX XXX, Senior Advisor, HealthCERT, XXX XXX, Senior Advisor, HealthCERT, XXX XXX Care Facility Manager, and XXX XXX, Village Manager. A copy of the letter of entry addressed to Ms XXX was provided. A proposed agenda for the day was discussed including a request to interview any relatives or health professionals visiting the facility during the course of the day. The inspection commenced with a tour of the facility.

Summary of Inspection findings

Relevant to the Complaint

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

Organisational Management - Standard 1.2

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

Partial attainment

The skin management policy on site was out of date (2008) and did not detail current accepted good pressure risk prevention and management practice. A new policy was provided due for release that week, but the new policy/procedure is still not in line with current good practice and does not provide sufficient detail to guide staff about pressure relieving equipment/processes.

Staff interviews and three of the six files reviewed identified these residents had current pressure ulcers (grades 1-4). The incident/accident policy and procedure does not specify that pressure ulcers require reporting.

Corrective Actions required by 15 March 2011

The provider is required to ensure that Clinical policies and procedures reflect current good practice, are up to date and provide sufficient detail to guide staff.

1.2.4.3 The service provider documents adverse, unplanned or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Partial attainment

Although several areas are monitored by the facility (infections, falls, skin tears, staff injury, complaints), adverse clinical events, specifically pressure ulcers were not evidenced as being monitored. It was evidenced that in four of six files evaluated there had been four pressure ulcers treated within the facility with three current pressure areas requiring wound management. There were no incident/accident forms for pressure ulcers in the residents' notes.

As there is no reporting of pressure ulcers within the organisation this adverse clinical outcome has not been addressed at the facility (no monitoring or being raised as a discussion at quality or staff meetings evidenced), or within the organisation in order to identify opportunities to improve service delivery and to identify and manage risk.

Additionally, of the six files reviewed two incident/accident forms were identified as not completed - one for a resident fall and one for a medication error.

Corrective Actions required by 15 March 2011

The provider is required to ensure that adverse, unplanned, or untoward events including service shortfalls are documented in order to identify opportunities to improve service delivery, and to identify and manage risk.

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

Six staff files were reviewed, three registered nurse and three care staff.

The Metlife registered nurse orientation programme includes spending three days with another registered nurse, and the completion of a self learning package within three months. There was no record of this orientation documentation in the two new registered nurse employee's files. Currently this documentation is held by the registered nurse until the three month follow-up and appraisal takes place.

One new registered nurse who's most recent employment was in a non-clinical role, received less than three days orientation.

Recommendation:

That the facility hold copies of the three day orientation check list on employees' files, and that all HR policies are followed without exception.

1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Partial attainment

The education/ training plan for staff covered all required areas and was met, however it was noted that there had been a low uptake of staff attending these programmes over the last year (six to eight staff from a total of 30 staff). These education programmes did not contain specific education to improve quality of care for this facility, e.g. prevention and management of pressure ulcers.

Corrective Actions required by 15 March 2011

The provider is required to ensure that:

1. All staff attend relevant education programmes provided within the facility.
2. When a quality improvement or change in process occurs, the education programme includes specific training to ensure staff knowledge of same.

1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.

Partial attainment

Not all entries in the residents' progress notes had legible signatures, name or designation entered.

White-out was used on the medication administration chart

Corrective Actions required by 15 March 2011

The provider is required to ensure that:

1. All residents' records are legible and the name and designation of the service provider is identifiable.
2. A single line is placed through any incorrect entry made in a residents' record, making sure the incorrect entry is still legible. Any amendments must be signed and dated.

1.2.9.10 all records pertaining to individual consumer service delivery are integrated.

Partial attainment

Residents wound care plans are kept in a separate folder.

Corrective Actions required by 15 March 2011

The provider is required to ensure that all residents' service provision records are integrated

Continuum of Service Delivery - Standard 1.3

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

Partial attainment

Staff Interviews and clinical files (three of six) indicate that there are residents with grade 1-4 pressure ulcers.

Personal cares/skin cares are part of the caregivers' daily work. Caregivers stated that if they have concerns about a residents skin status, they would ask the registered nurse on duty for advice. Caregivers do not undertake wound care/dressings.

Caregivers interviews identified that not all staff were competent in the use of pressure relieving mattresses/equipment.

Corrective Actions required by 15 March 2011

The provider is required to ensure that all staff are educated on the selection, use and maintenance of pressure relieving devices and risk assessment tools to ensure interventions are planned and implemented to meet the desired outcome.

1.3.4.1 Service providers seek appropriate information and access a range of resources to enable effective assessment.

Partial attainment

The current skin management policy is out of date and does not provide sufficient detail to guide staff on the required interventions for grade 1-4 pressure ulcers.

The waterlow pressure risk assessment tool is used and completed three monthly (This was evidenced in all files reviewed). There was no evidence of the assessment being completed more regularly for high risk residents (waterlow pressure risk score in 3 files was 25 + or very high risk) and when a person condition/treatment changed within that time.

Corrective Actions required by 15 March 2011

The provider is required to ensure that:

- 1 Staff seek appropriate information and are able to access appropriate resources to enable effective assessment of pressure ulcer risk/areas. Specifically, residents must be re-examined according to their level of risk and change of condition
- 2 Decisions on best pressure relieving practice should be made within the multidisciplinary team meeting and this process needs to be documented and communicated to staff.

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

Partial attainment

Caregivers identified that not all staff were competent in the use of pressure relieving mattresses/equipment. Bed clothing was impacting on pressure relieving measures in place. There was no evidence that Pressure area/risk management education has taken place.

Corrective Actions required by 15 March 2011

The provider is required to ensure that:

1. Interventions are guided by current good practice policy and procedures, are appropriate to the assessed need/risk and undertaken by suitably skilled staff.
2. Required interventions are accurately communicated (staff shift-handovers, Multidisciplinary team meetings, family) and documented, for all service providers to

follow. Equipment type and use must be specified in sufficient detail in the care plan to guide staff.

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.

Partial attainment

A respite resident had no medicine/prescription chart current for this admission. Medications had been administered for eight days without a current medication chart. Additionally, there was no photo ID in the folder.

Corrective Actions required by 15 March 2011

The provider is required to ensure that:

1. Only prescribed medications are administered.
2. All residents must have a current signed (by an authorised prescriber) medication chart.

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

One resident file and a staff interview identified a resident who was prescribed and given a medication they were allergic to as documented in their care plan. An RN identified that the medication prescription was changed and then the allergy was added to the medicine chart. There was no adverse reaction recorded in the clinical records, an RN interview confirmed the resident did not have an adverse reaction. No incident form was completed re this medication error.

Partial attainment

The provider is required to ensure that all allergies and sensitivities are recorded as per the organisations medication policy and procedures and incident forms are completed in relation to medication errors/near misses.

Safe and Appropriate Environment - Standard 1.4

1.4.2.3 Amenities, fixtures, equipment, and furniture are selected, located, installed, and maintained with consideration of consumer and service provider safety, needs, and abilities.

Partial attainment

All Staff interviewed identified there has been an issue with the availability of clinical supplies to carry out required interventions, such as single use syringes/needles and dressing supplies.

Staff interviews identified not all staff were confident in the use of the pressure relieving equipment available.

Corrective Actions required by 15 March 2011

The provider is required to ensure that:

1. The appropriate resources/supplies are available for staff to carry out required interventions.
2. All pressure relieving equipment used is reviewed immediately.

1.4.6.1 Written policies and procedures are implemented and describe each cleaning and laundry process appropriate to the service setting and consumer group.

Cleaning policy and processes are in place and understood by cleaning staff. A cleaner is employed for 6 hours 7 days per week.

The facility is clean, however the carpets in lounge and dining areas are badly stained giving an appearance of being dirty. In addition the join running through the middle of the lounge carpet is frayed and beginning to lift. It was noted in the 2010 internal audit that the carpet in the dining and lounge areas was in need of repair/replacement

Recommendation:

1. That the provider gives consideration to moving forward the commercial cleaning, repair/replacement of the lounge and dining room carpets.
2. That the provider review the cleaning hours for the facility.

Summation meeting

A summation meeting was attended by:

XXX XXX Senior Advisor, HealthCERT ; XXX XXX Senior Advisor, HealthCERT; XXX XXX, Health of Older People Planning and Funding Manager DHB; XXX XXX XXX, National Clinical Manager Metlifecare; XXX XXX Village Manager Metlifecare; XXX XXX Care Manager Metlifecare.

XXX XXX thanked the facility for their participation and approach to the investigation recognising that this was an unannounced inspection. It was explained that a full summation of findings could not be provided at the closing meeting as information gathered needed further analysis. XXX XXX noted that one relative interview was completed and that the relative had been complimentary about the service, noting that staff were approachable. XXX XXX confirmed that there would be substantiated findings against the Health and Disability Services Standards and these would be likely to include the following areas:

- Policies being up to date, implemented and known by all staff –skin management policy not current.
- Use of and availability of equipment – staff report there have been issues with lack of equipment and staff knowledge of pressure relieving equipment .
- Adverse event reporting – all incidents/near misses are not reported through adverse event process - no pressure ulcers are reported and a drug error and fall were not documented as reported in the files reviewed.
- Care interventions –lack of knowledge of staff undertaking interventions.
- Medication management – medication was administered with out a current medication chart signed by an authorised prescriber.
- Documentation – wound care plans are not integrated, not all clinical records contained legible staff names and designation and white out was used.

Key issues raised at summation were:

The need for the provider to address the concerns identified immediately.

The provider communicated a willingness to work proactively on the improvements required and to work with the DHB staff to ensure actions reflected good practice.

The DHB undertook to provide clinical oversight and support.

Cleanliness of the facility, infection control and food service aspects of the complaint were unsubstantiated.

Conclusion

Metlifecare Coastal Villas will be required to take the above corrective actions to improve compliance against the Health and Disability Services Standards. Ongoing monitoring will be undertaken by the Ministry in conjunction with the DHB.

The complaint about aspects of the clinical management provided by Metlifecare Coastal Villas, alleged that medication administration, wound/pressure care interventions, staff training and reporting processes were not adequate was substantiated. The cleanliness of the facility, infection control and food service aspects of the complaint were unsubstantiated.

Additional Conditions

Additional condition to be placed on the Certification Schedule:

A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards: 1.2.3.4, 1.2.4.3, 1.2.7.5, 1.2.9.9, 1.2.9.10, 1.3.3.1, 1.3.4.1, 1.3.6.1, 1.3.12.1, 1.3.12.4, and 1.4.2.3 as identified in the Inspection Report must be submitted to your District Health Board by 11 March 2011. Your District Health Board will notify the Director-General of Health of progress, if any, if required in accordance with the Ministry of Health's requirements for the processing of progress reports.

Summary for Publication

The Ministry of Health received a complaint about the standard of care provided to residents at Metlifecare Coastal Villas.

The purpose of the unannounced inspection undertaken on 14 February 2011, was to determine whether health care services being provided by Metlifecare Coastal Villas were being provided in compliance with section 9 of the Health and Disability Services (Safety) Act 2001 (that is a person providing health care services of any kind must do so whilst meeting all relevant standards).

Corrective actions are required for the findings identified specific to the complaint and inspection in the following areas:

Organisational Management:

The organisation must ensure that the skin management policy and guidelines are up to date, reflects current good practice and are available to staff. All care providers must receive relevant pressure ulcer prevention/care education to support safe and effective care of consumers. In addition care providers are required to be fully aware of the organisational requirements regarding clinical documentation and recording and reporting adverse events.

Continuum of Service Delivery:

Interventions must be appropriate to the assessed needs and staff must have the required knowledge and skill to carry out the required interventions. All residents must have a current medication chart signed by an authorised prescriber.

Safe and Appropriate Environment:

Metlifecare Coastal Villas must ensure that appropriate equipment is available and used in accordance with assessed need. Staff should be educated in the use of all pressure relieving equipment. Equipment type and use must be specified in sufficient detail in the care plan to guide staff.

Metlifecare Coastal Villas is required to complete the required corrective actions by 15 March 2011. Ongoing monitoring will be undertaken by the District Health Board in conjunction with the Ministry of Health.

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