Fitzroy Village Management (2016) Limited - Fitzroy of Merivale

Introduction

This report records the results of a Provisional 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.

The specifics of this audit included:

Legal entity:	Fitzroy Village Management (2016) Limited
Premises audited:	Fitzroy of Merivale
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 24 February 2016 End date: 24 February 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:	23

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.

General overview of the audit

Fitzroy of Merivale provides rest home services for up to 31 residents. On the day of audit, there were 23 rest home residents.

This provisional audit was conducted against the relevant Health and Disability Standards and the agreement with the district health board, due to the proposed sale of the business. The audit process included a review of policies and procedures, a review of resident and staff files, observations, and interviews with residents, families, staff, the current and prospective provider and a general practitioner.

The prospective purchaser is a husband and wife team. One is an experienced RN with a background in DHB medical and stroke care. The intention is for her to become the facility manager (RN) with support from the current deputy manager. The other owner/director will take on an administrative/accounts role. All other existing staff (with exception of the part time RN) will be re-employed by the prospective purchaser under the same terms and conditions of employment. The prospective purchaser does not

own any other aged care residential facilities in New Zealand, however has owned and managed other companies. The current owner/manager is contracted to provide support for two weeks from the date of purchase and there is a transition plan in place, which identifies current and anticipated organisational risks

Improvements are required around care plan interventions and enabler documentation.

Consumer rights

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (i.e., the Code) are in place. Posters on the Code are displayed in the facility. Information about the Code and services are readily available to residents and families. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are managed and documented. There is a Māori Health Plan and implemented policy supporting practice. Residents and family interviewed verified that their rights are respected.

Organisational management

The current and prospective governance arrangements were reviewed. There is an implemented quality and risk management plan. Key components of the quality programme link to the staff/quality meetings. An annual resident/relative satisfaction survey is completed and there are bimonthly resident meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme in place that provides new staff with relevant information for safe work practices. There is an in-service training programme covering relevant aspects of care and support. The facility staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

Residents are screened and approved prior to entry to the service. There is an admission package available prior to or on entry to the service that includes information on the services provided at Fitzroy of Merivale rest home. The deputy manager /registered nurse is responsible for each stage of service provision. The deputy manager/registered nurse assesses, develops care plans and reviews residents' needs, outcomes and goals with the resident and/or family. Resident files included medical notes and notes of other visiting allied health professionals.

The diversional therapist coordinates and implements an interesting and varied activities programme for the residents that includes outings and community involvement.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines, complete annual education and medication competencies. The general practitioner reviews medication charts at least three monthly.

All meals are provided by a contracted service. A dietitian has reviewed the menu. Individual and special dietary needs are accommodated and alternative options are available for residents with dislikes.

Safe and appropriate environment

The building holds a current warrant of fitness. Rooms were individualised. All bedrooms have full ensuite. External areas were safe and well maintained. The facility has a van available for transportation of residents. Communal dining and lounge areas are easily accessed. Resident's rooms, ensuite and communal areas all have call bells. Fixtures, fittings and flooring are appropriate for rest home level care. Emergency management procedures are in place. Cleaning and laundry services for personal clothing were maintained. Linen and towels are laundered off-site. Chemicals were stored securely. The temperature of the facility was comfortable and constant and able to be adjusted in resident's rooms to suit individual resident preference. The service has implemented policies and procedures for fire, civil defence and other emergencies. There is a first aider on duty at all times. Fire drills have been conducted six monthly.

Restraint minimisation and safe practice

There were comprehensive policies and procedures in place that met the restraint standards. There was a restraint coordinator with delegated responsibilities for monitoring enabler/restraint use and compliance of assessment and evaluation processes. Behaviours that challenge are discussed at staff meetings. There was one resident using an enabler and no residents assessed as requiring restraint.

Infection prevention and control

The infection prevention and control programme includes policies and procedures to guide staff. The deputy manager (RN) is the infection prevention and control coordinator. An infection prevention and control register is used to document infections. A monthly infection control report is completed and analysed. Training is provided annually to staff.

Summary of attainment

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

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	43	0	2	0	0	0
Criteria	0	91	0	2	0	0	0

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.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The service provides information to residents that include the Code of rights, complaints and advocacy information. Interviews with five residents and one relative identify they are informed about the code of rights. The manager and deputy manager (RN) provide an open-door policy for concerns or complaints. Resident meetings have been held providing the opportunity to raise concerns in a group setting. A resident satisfaction survey has been conducted. Advocacy pamphlets, which include contact details, are included in the information pack and are available. The service has an advocacy policy that includes contact details.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Written informed consent is gained for general consents and were sighted in the five resident files sampled. Resuscitation advance directives had been signed by the resident and general practitioner. Residents interviewed confirm they were given information to be able to make informed choices. The deputy manager (RN) and caregivers interviewed could describe how consent is gained when carrying out

		residents daily cares. Discussion with a family member identified the service actively involves them in decisions that affect their relative's lives.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder on admission and in advocacy pamphlets that are available in the residents TV lounge. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. The residents' files include information on residents' family/whānau and chosen social networks. Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry. Discussions with relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The resident information pack states that visiting can occur at any reasonable time. Interviews with residents and one relative confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans. Discussions with residents and relatives verify that they are supported and encouraged to remain involved in the community. Fitzroy of Merivale staff support ongoing access to the community and entertainers are invited to perform at the facility
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedure is in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. There are

		complaint forms available in the TV lounge for residents. Information in the admission pack includes the contact details for the Health and Disability Advocacy Service. Interviews with residents and relatives confirmed they were familiar with the complaints procedure and state any concerns or issues are addressed. The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. All three complaints documented for 2015 were reviewed. Complaints have been followed up appropriately with resolution.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	On entry to the service, residents/family receive an information pack that includes code of rights information and a resident admission agreement. The manager or deputy manager (RN) discusses the information pack with the resident and the family/whānau on entry. This includes the code of rights, complaints and advocacy. Health and Disability advocacy service leaflets are available to residents and family in the service entrance. On interview with two caregivers, they described how they take time to explain the rights to residents and their family members. Residents interviewed confirmed that they had received information about their rights on entry to the service. The prospective director's confirmed in interview that they are committed to ensuring residents receive services in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and	FA	The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. The service has a philosophy/vision and mission that promotes quality

independence.		of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Residents and relatives interviewed confirm the service is respectful and independence is supported. Resident files include their cultural and/or spiritual values when identified by the resident and/or family. Discussions with residents confirm that they are able to choose to engage in activities and access community resources. Staff education and training on abuse and neglect has been provided.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There is a Māori heath plan and ethnicity awareness policy, which includes cultural safety and awareness. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau. There is information and websites provided within the Maori health plan to provide quick reference and links with local Māori. Interviews with staff confirm they are aware of the need to respond appropriately to maintain cultural safety. Currently, no residents identify as Maori at Fitzroy. Policies include guidelines about the importance of whānau. Cultural safety training has been provided for staff in 2015.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Care planning includes consideration of cultural and spiritual needs. Residents interviewed indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives report that they feel they are consulted and kept informed. The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by the registered nurse.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of house rules and a Fitzroy code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on

		dignity and privacy and boundaries. Interviews with staff confirm their understanding of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The quality programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. The recent resident satisfaction survey reflects high levels of satisfaction with the services that are received. Policies and procedures have recently been reviewed. These are available in hard copy and electronically. There are combined staff/quality meetings and residents meetings conducted. Residents and relatives interviewed spoke very positively about the care and support provided. Staff had a sound understanding of principles of aged care and state that they are well supported by the manager and deputy manager. The training programme exceeds eight hours annually and the majority of the staff have an aged care qualification. There is currently registered nurse onsite cover across seven days. Quality improvements/initiatives are implemented. There are implemented competencies for caregivers and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Policies are in place relating to open disclosure. Residents interviewed state they were welcomed on entry and given time and explanation about the services and procedures. A sample of incident reports reviewed, and associated resident files, evidenced recording of family notification. Relatives interviewed confirm they are notified of any changes in their family member's health status. The manager and deputy manager were able to identify the processes that are in place to support family being kept informed. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of

		services and any items they have to pay for that are not covered by the agreement. The facility has an interpreter policy to guide staff in accessing interpreter services.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Fitzroy of Merivale provides rest home level care for up to 31 residents in serviced units. Services are provided under the aged residential care agreement and the respite care agreement. On the day of the audit there were 23 residents including 10 subsidised residents. There were no respite residents on the day of audit. All but five of the 30 units are LTOs; one unit is a double unit. The service has a documented quality improvement programme that includes the quality and risk management plan, which is reviewed annually. There is a strategic plan 2014 – 2018. The current owner/facility manager (RN) has been in the role for the last 2.5 years and has many years' experience in management and aged care. She is supported by an experienced aged care clinical manager in the role of deputy manager and a part time RN (2 days a fortnight). The prospective purchaser intends to make no changes to the existing employment arrangements of the deputy manager (RN). The prospective purchaser is a husband and wife team. One is an experienced RN with a background in DHB medical and stroke care. The intention is for her to become the facility manager (RN) with support by the current deputy manager. The other owner/director will take on an administrative/accounts role. All other existing staff (with exception of the part time RN) will be re-employed by the prospective purchaser under the same terms and conditions of employment. The prospective purchaser does not own any other aged care residential facilities in New Zealand, however has owned and managed other companies. The current owner/manager is contracted to provide support for two weeks from the date of purchase and there is a transition plan in place, which identifies current and anticipated organisational risks.

Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During a temporary absence of the current owner manager, the deputy manager (RN) oversees the management role. The prospective provider intends to make no changes the current structure. The deputy manager will continue overseeing the role when the facility manager is away.
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.	FA	A quality improvement programme is in place that is ongoing with objectives, action plans, responsibilities and date/timeframes. The facility manager and deputy manager both manage the quality system with support from the staff. There are a range of policies, associated procedures and forms in place. Policies have been updated to include reference to InterRAI LTCF procedures. The policies and quality system are accessed from an external consultant, which includes reviewing and updating. There is a combined bimonthly quality/staff meeting which includes (but not limited to) quality assurance discussion, internal audit outcomes, health and safety, infection control, complaints and restraint as needed. There are also quarterly RN clinical meetings. The service has bimonthly resident meetings. There are annual satisfaction surveys to encourage resident and family participation. The surveys have been reported back to staff and residents with evidence of changes made because of survey feedback. There is an implemented schedule of internal audits. Corrective action format is used for audits, meeting minutes and reports. Incident and accident reporting and health and safety are all linked to the quality and risk management system. A monthly analysis and trends summary is completed for incidents/accidents and infections. There is a risk management register. Risks are monitored through implementation of quality activities and reviewed though meetings. The prospective purchaser will use the existing quality and risk management plan. A contract with an external aged care consultant will continue to maintain review and update policies and procedures, and quality system. Incidents/accidents and infections will continue to be inputted and analysed through the external consultant and

		benchmarking will commence.
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	There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise, and debriefing. The service collects incident and accident information. The reporting system is reported and monitored through combined quality meetings. Incidents are imputed electronically through their external consultant. Monthly incidents are then graphed, analysed and trends identified. Once incidents and accidents are reported, the immediate actions taken are documented in incident forms. A review of six incident forms and related resident files from January 2016 identify registered nurse follow up. The manager and deputy manager were aware of the statutory and regulatory obligations to report essential information to external agencies.
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 job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. Practising certificates were sighted for the RNs. Four staff files were reviewed including the files of two caregivers, deputy manager, and the diversional therapist. The deputy manager and RN have been InterRAI trained. There is an annual appraisal process in place and appraisals are current in the files reviewed. New staff complete an orientation that was sighted in the files reviewed. The service has a training schedule for in-service education. The in-service schedule is implemented and attendance recorded at sessions kept, each session includes an attendance sheet. Interview with caregivers indicated there is access to sufficient training. The prospective purchaser advised they will complete new employment contracts for all staff and contracted providers.
Standard 1.2.8: Service Provider Availability	FA	There is a policy and procedure on annual leave and rostering.

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		Staff/skill mix expectations are outlined in the policy document, as are sections on the routine roster, support staff and replacing staff. Guidelines regarding consecutive days, holidays and changes of shift are also documented. An acuity tool is used to determine resources required. The facility manager, with feedback from the deputy manager, develops the roster. The caregivers interviewed report that there is sufficient staff cover. The prospective provider advised they will re-employ all existing staff under the same terms and conditions of employment. The prospective provider will continue to operate the existing policy regarding staff skill mix and staff according to contractual obligations, taking into consideration the acuity of consumers within the service. The current position of casual RN that works every second weekend is the only change planned to the existing staffing arrangements.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Prior to entry to the service residents are assessed by a needs assessment and service coordination agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. The RN conducts InterRAI assessments. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident files are integrated and they include GP input and reviews. Resident files are stored securely and protected from unauthorised access. Only relevant personnel can access records. Care plans and progress notes are legible and signed by staff making the entry. Medical notes are signed and dated appropriately.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Prior to entry, potential residents have a needs assessment completed. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The information pack includes all relevant aspects of the service. The admission agreement reviewed aligns with a) -k) of the ARC contract and document any additional charges.

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies to describe guidelines for death, discharge, transfer, documentation and follow up. A record is kept and a copy of details is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service.
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.	FA	Medication policies and practice align with accepted guidelines and legislative requirements. The facility manager/RN, deputy manager/RN and caregivers responsible for the administration of medications have completed annual competencies and medication education. Medications are checked on arrival by the registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy. There were three self-medicating residents (inhalers) on the day of audit. Self-medication competencies and three monthly reviews had been completed and signed by the RN and GP. Standing orders were not in use. Verbal orders taken are signed off by the GP at the weekly visits. Signing sheets reviewed corresponded with the medication charts. Ten medication charts were reviewed. Prescribing of medication met legislative requirements. Medication charts had photo identification and allergy status documented.
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	The provision of all meals and baking is contracted out. Meals are delivered to the facility in hotboxes. The dietitian for the contracted service reviews all menus with the last review in September 2015. A morning and afternoon kitchen assistant employed by the provider is responsible for the serving of all meals from the bain-marie. The contracted service and kitchen assistants know resident's likes and dislikes. Alternative foods are provided as confirmed in resident interviews. Dietary requirements such as high calorie diets, diabetic desserts and vegetarian diets are provided. There are snacks and breakfast foods readily available. The facility has a fully functioning industrial kitchen with oven,

		microwave, fridge, freezer and dishwasher. Fridge and freezer temperatures are taken and recorded daily. The chemical provider checks the dishwasher temperature monthly. All foods and perishable foods sighted in the fridge had date labels. A cleaning schedule is maintained. A hand washing station and personal protective wear is available for kitchen staff. Kitchen assistants have completed food safety and hygiene training.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service would record reasons for declining entry to residents should this occur and refer the resident/family/whānau back to the referral agency.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Nursing and risk assessments reviewed were completed in a timely manner using recognised tools to assess the resident's needs. Long-term residents files reviewed had six monthly InterRAI assessments completed. A full nursing assessments and risk assessments were completed where applicable for the respite care residents. Risk assessments, where applicable, had been reviewed six monthly or earlier for health changes. Not all care plans reflected appropriate interventions for the identified level of risk (1.3.6.1).
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	In all four files of permanent residents, the RN completed the long-term care plan within three weeks of admission. Care plans describe the resident goals, supports and interventions required to meet desired goals, however there was a shortfall around documented supports and interventions for residents with identified falls and pressure injury risk (1.3.6.1). There is documented evidence of resident and/or family input ensuring a resident focused approach to care. Resident files reviewed identified that family were involved. There was evidence of allied health care professionals involved in the care of the resident. Short-term care plans are used for changes in

		health status.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit. There is evidence of three monthly medical reviews or earlier for health status changes. Staff report there are adequate continence supplies and dressing supplies. On the day of the audit, supplies of these products were sighted. There were two wounds being treated on the day of audit. One chronic wound had daily wound care evaluations and dressing plans in place and was linked to the long-term care plan. There was evidence of specialist involvement. The Canterbury District Health Board wound assessment form was in place. There were no pressure injuries being treated on the day of audit. The deputy manager/RN could describe the referral process to a wound specialist or continence nurse.
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	The service employs a qualified diversional therapist (DT) for three days a week and an activity assistant for two days a week to deliver the Monday to Friday activity programme. The DT plans and oversees the activity programme, which provides a variety of activities that are meaningful to the residents, including household tasks such as setting tables and feeding animals. One on one activity time is scheduled into the programme for those residents who do not wish to participate in the group activities. Exercises are held regularly and residents were observed walking around the spacious grounds. There is weekly entertainment and outings up to twice a week. Community links are maintained with visits out into the community for shopping, cafes and concerts. Residents are encouraged to maintain former links with community groups such as the RSA. The village has a van for transport and use the Miss Daisy service for residents to attend community activities of their choice. Church services are held on-site monthly. Each resident completes a personal profile on admission. Individual activity plans are reviewed six monthly at the same time as the clinical

		care plan review. Residents spoke positively about the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The RN has evaluated initial nursing assessments/care plans in resident files reviewed, within three weeks of admission. Long-term care plans had been reviewed at least six monthly by the deputy/RN in consultation with the resident or family, care staff and GP. Written evaluations and InterRAI assessments were evident in the files of permanent residents. Families are invited to attend the MDT meeting. Evaluations are dated and documented on the care plan, against each resident goal. Short-term care plans have been reviewed by the RN and either resolved or added to the long-term care plan if the problem is ongoing.
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	The deputy manager/RN could describe the referral process to other medical and non-medical services. Referral documentation was maintained on resident files. The service provided an example of where a resident's condition had changed and the resident has been reassessed for a higher level of care, for example from respite care to rest home level of care (also link 1.3.6.1).
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies in place for waste management, waste disposal for general waste and medical waste management. All chemicals are labelled with manufacturer labels. Chemicals are stored in a locked cupboard. Chemical product use and safety data sheets are available. Gloves, aprons, and goggles are available for staff. Staff were observed to be wearing appropriate personal protective clothing when carrying out their duties. Staff have received education in chemical safety.
Standard 1.4.2: Facility Specifications	FA	The service displays a current building warrant of fitness, which expires on 31 July 2016. A maintenance person is employed five days a week

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		and completes the reactive maintenance and planned maintenance as directed by the owners. A maintenance request book is in the staff room and repairs were sighted to be signed off within a timely manner. The facility is well maintained. Hot water temperature checks were conducted and recorded monthly. There is evidence of corrective actions where temperatures have been outside of the acceptable range. An external contractor has serviced medical equipment annually. Electrical equipment is serviced two yearly. Residents were observed to safely mobilise throughout the facility with easy access to communal areas. There is safe access to outdoor gardens and courtyards provided seating and shade. Interviews with staff confirmed there was adequate equipment to provide safe and timely care.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All rooms are single with full ensuite. There is a communal/disabled toilet located near the dining area. Fixtures, fittings and floor and wall surfaces are made of accepted materials for ease of cleaning. Residents interviewed state their privacy and dignity is maintained while staff are attending to their personal cares and hygiene.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Bedrooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. Caregivers interviewed report that rooms have sufficient space to allow cares to take place. The bedrooms are personalised. The bedroom furnishings and seating were appropriate for the resident group.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining	FA	There is a large dining room and open plan lounge. There is an additional smaller lounge/television room and seating alcoves. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to

needs.		be moving freely within the communal areas throughout the audit. Residents interviewed report they can move freely around the facility and staff assist them if required.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All linen and towels are laundered by a contracted service. Personal clothing is laundered on-site. There is a small functioning laundry with entry and exit doors and defined clean/dirty areas. Adequate linen supplies were sighted within the facility. There is a designated housekeeper on duty Monday to Friday to complete cleaning and laundry duties. Caregivers complete cleaning and laundry duties as required. The cleaning trolley is stored securely when not in use. The chemical provider monitors the effectiveness of laundry processes.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an emergency plan in place, a fire policy and evacuation plan. Fire drills occur six monthly. There is a staff member across 24/7 with a current first aid certificate. Alternative energy supplies that are available in the event of the main supplies failing include two gas barbecues for cooking purposes, torches for lighting and spare blankets for warmth. Stocks of additional food and water are available. The contract for the provision of meals to the service includes the supply of emergency food should the need arise. The call bell system is in place and functional. This is linked to a pager system. Residents report staff respond to the call bell in a timely manner. Security arrangements are in place.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated.

Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Fitzroy of Merivale has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked to the quality management programme. The deputy manager (RN) is the designated infection control nurse with support from the facility manager, GP and care staff. The IC team is part of the bimonthly quality meeting. Minutes are available for staff. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff. The infection control programme has been reviewed annually. There is an outbreak management kit available. There have been no outbreaks.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The deputy manager is the infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) nurse maintains her practice by attending annual infection control updates. The IC nurse has good external support from the local laboratory infection control team and GP. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is all freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There is infection control policy and procedures appropriate for the size and complexity of the service. The safe & appropriate environment manual outlines a comprehensive range of IC policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Annual IC training has been provided to staff by southern community laboratories. All infection control training is documented and a record of attendance is maintained. The IC nurse also attends external training. Information is provided to residents and visitors that is

		appropriate to their needs and this is documented in medical records. Standard precautions and hand hygiene audits are undertaken with staff.
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	Infection surveillance is an integral part of the infection control programme and is described in the monitoring policy and antimicrobial policy (definitions). Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection register. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	PA Low	There is restraint minimisation and safe practice policies applicable to the service. Associated documents, guidelines and forms for the assessment and authorisation for enabler and restraint use, monitoring, review and evaluation of restraints used are available. Restraint and Enabler Use policy ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. The service remains restraint-free. There is one resident with a bedrail identified as an enabler. However, no documentation has been completed as per policy.

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (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 Low	Residents and relative interviewed confirm care delivery and support by staff is consistent with their expectations. There is documented evidence of family notification for infections, accident/incidents, GP visits, care plan reviews and any changes to health status. Care plans are updated with changes to care. Short-term care plans document changes to health and the interventions required to meet the resident’s needs. The service has a standing hoist which is currently used for transfers due to one residents declining mobility. The resident care plan includes the use of the hoist with two persons at all times. There is policy in place for the use of the hoist, which states two	(i) Two residents assessed as high falls (one resident is a frequent faller), do not have documented falls prevention strategies to reflect the level of risk. (ii) One resident assessed as moderate risk of pressure injury due to declining mobility, does not have appropriate pressure injury interventions documented. The resident’s health status has declined requiring two person standing hoist transfers, two hourly toileting, full assistance with all personal cares and regular repositioning for the prevention of pressure injuries. The care plan states the resident is immobile requiring two staff for all transfers/cares with a standing hoist. The first InterRAI assessment was completed September	(i) & (ii) Ensure interventions documented meet the resident’s current level of risk for falls and pressure injuries. Complete a further InterRAI assessment due to changes in health status. Ensure the resident is re-assessed to ensure the resident is receiving the correct level of care. Since the draft report the new manager has stated a document review will occur within the next 21 days. 60 days

		persons are required for all hoist transfers. The staff have completed hoist competencies that align with the policy.	2015.	
Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	PA Low	Relevant definitions for enablers and different forms of restraint are in the policy. The policy describes the definition of enablers and link to related forms.	There is a bedrail in use for safety (enabler). There is no authorisation/consent form completed, enabler assessment or register completed as per the policy. Training has not been provided to staff around enabler use in the last two years.	Ensure documentation reflects that the restraint is voluntary, an assessment is completed to identify risks and the register is up to date. Ensure training has been provided to staff around enabler use and the policy. 30 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.