Fitzroy Village Management (2016) Limited - Fitzroy of Merivale

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.

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: 26 November 2018 End date: 27 November 2018

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 26

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

Indicator	Description	Definition
	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

Fitzroy of Merivale provides rest home level care for up to 31 residents. On the day of the audit there were 26 residents living at the facility, including four boarders.

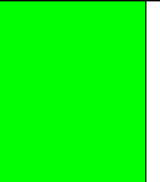
This surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The owner/clinical manager is a registered nurse. She is appropriately qualified and experienced and is supported by a second registered nurse. Residents interviewed were complimentary of the service they receive.

The service has an established quality and risk management system. Residents and the general practitioner interviewed commented positively on the standard of care and services.

This audit identified that the service was fully compliant to the standards audited.

Consumer rights

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.

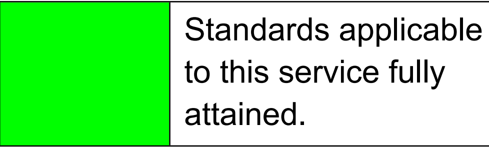
The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents interviewed verified ongoing involvement with the community.

Organisational management

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.		Standards applicable to this service fully attained.

Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are established. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff. The health and safety programme meets current legislative requirements. Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training are in place. Registered nursing cover is on site during the day across seven and on-call available twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

Continuum of service delivery

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.		Standards applicable to this service fully attained.

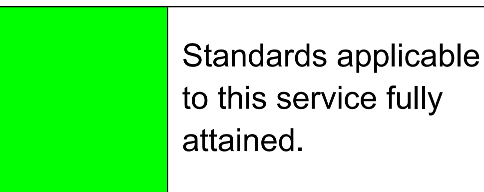
A registered nurse assesses and reviews each resident's needs, outcomes and goals at least six monthly. Care plans demonstrated service integration. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior carers 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 diversional therapist implements the activity programme for the residents. The programme includes community visitors, outings and activities that meet the individual and group recreational preferences for the residents.

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

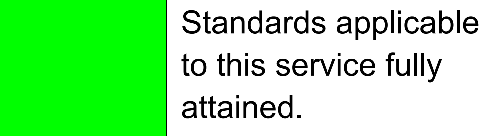
Safe and appropriate environment

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 building warrant of fitness that expires 1 August 2019.

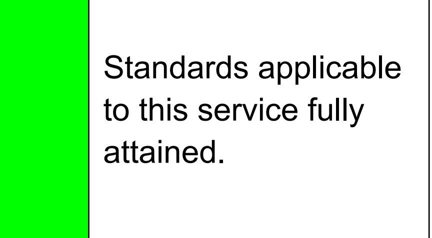
The director/health and safety officer has responsibility for the maintenance and repairs of the facility. There is a planned maintenance schedule in place. There is sufficient space for residents to safely mobilise using mobility aids, and communal areas are easily accessible. There is safe access to the outdoor areas. Seating and shade is provided.

Restraint minimisation and safe practice

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. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. There was no restraint or enablers in use.

Infection prevention and control

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. There are 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 since the previous audit.

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	16	0	0	0	0	0
Criteria	0	41	0	0	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and families during the resident's entry to the service. Access to complaints forms are located at reception. The complaints process is linked to advocacy services. A record of complaints received is maintained by the clinical manager using a complaint register. Three consumer complaints were received 2018, year to date. Documentation evidenced that these complaints were managed in accordance with set guidelines. All complaints were documented as resolved. Discussions with five residents confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly. There was no family available to interview on the days of audit.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	There is a policy to guide staff on the process around open disclosure. The owner/clinical manager (clinical manager) confirmed family are kept informed. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents There is access to an interpreter service as required.

communication.		
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 is owned and operated by two owners/directors. The service can provide rest home level care for up to 31 residents. All but nine of the 29 units are licensed to occupy (LTO) including two double units. On the day of audit there were 26 residents at rest home level care including two respite residents. Four additional residents (boarders) also live at the service in the LTO rooms. A philosophy, mission, vision and values are in place. The strategic plan (2016-2020) is regularly reviewed with the facility manager/owner, director/owner and an external consultant. There is an implemented quality system. One owner/director is the clinical manager/RN. She has 25 years of public health nursing experience and has maintained over eight hours of professional development relating to the management of an aged care facility. She is supported by the second owner/director (her spouse) who is responsible for maintenance and health and safety. A second (part-time) RN is rostered to support the manager.
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	Fitzroy of Merivale has a well-established and comprehensive quality and risk programme. There are annual reviews documented for activities, health and safety, risk management and infection control. This information has been used to formulate ongoing service reviews and training. There are policies and procedures 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. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Data is collected for a range of adverse event data (eg, skin tears, bruising, falls, infections) and is collated and analysed. Quality data and outcomes are discussed with staff in the two monthly quality meetings. There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Corrective actions are developed, implemented and signed off. Internal audits are discussed at service meetings. A risk management plan is in place. Health and safety policies have been updated to reflect new legislative requirements. Interviews were conducted with the health and safety officer who also is one of the owner/directors. He has attended health and safety training through Worksafe NZ. Staff confirmed they are kept informed on health and safety matters at meetings. Staff health and safety training begins during their induction to the service. Health and safety is a regular topic covered in the two-monthly quality/staff meetings. Actual and potential risks are documented on a hazard

		register, which identifies risk ratings and documents actions to eliminate or minimise the risk. Contractors are inducted into the facility's health and safety programme. Falls management strategies include sensor mats and the development of specific falls management plans to meet the needs of each resident who is at risk of falling.
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. Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme. Ten accident/incident forms were reviewed from over a period of three months. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations were conducted for suspected head injuries. The clinical manager is aware of statutory responsibilities in regard to essential notification with examples provided and no notifications have been needed since the previous audit.
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	Human resources policies are in place and continue to be implemented. Five staff files reviewed (one RN, and four caregivers,) included evidence of the recruitment process including reference checking, signed employment contracts and job descriptions, and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice. Competencies are completed specific to worker type. Staff interviewed stated that they believed new staff were adequately orientated to the service. There is a comprehensive annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. A register of current practising certificates for health professionals is maintained. The clinical manager has completed interRAI training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service	FA	The staffing policy aligns with contractual requirements. One RN is on site during the day seven days a week with an RN on call over 24 hours. Staff inform that the on-call RN is always supportive and will come to the facility anytime. The clinical manager is an experienced RN who works full time and shares weekend responsibilities with a second RN. There are adequate numbers of caregivers available with one caregiver rostered during the night shift and three caregivers rostered on the am and pm shifts. Staffing is flexible to meet the acuity and needs of the residents.

providers.		A separate cleaner is employed. Caregivers are responsible for laundry duties. Interviews with residents confirmed staffing overall was satisfactory.
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	The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented. All medicines are stored securely when not in use. A verification check is completed by the clinical manager or RN against the resident's medicine order when new medicines are supplied from the pharmacy. Short-life medications (ie, eye drops and ointments) are dated once opened. Education on medication management has occurred, with competencies conducted for the registered nurse and caregivers with medication administration responsibilities. Administration sheets sampled were appropriately signed. Ten medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A caregiver was observed administering medications and followed correct procedures.
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	Meals and baking are provided by an off-site contracted service. A dietitian approves the four-seasonal menu. The contractor receives resident dietary information including dislikes and food allergies. Meals are transported to the facility kitchenette and served by the morning and afternoon staff who are employed by the service. Any special dietary requirements are delivered in named containers. Residents interviewed were very complimentary about the meals provided. Serving temperatures are checked on delivery and recorded. Fridge temperatures are monitored and recorded daily. All perishable goods were date labelled. A cleaning schedule is maintained. All staff and kitchenhands involved in the preparation of breakfasts and serving of meals have attended food safety training. Recent initiatives have included reviewing and changing aspects of the menu following resident feedback.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet	FA	Care plans sampled were goal orientated. All four long-term care plans sampled have interventions documented. Care plans have been updated as residents' needs changed. The respite resident has a short-term care plan documented. When a resident's condition changes, the clinical manager or RN will initiate a GP consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited

their assessed needs and desired outcomes.		to) accident/incidents, infections, health professional visits and changes in medications. Adequate dressing supplies were sighted, including an initial dressing box for caregivers to use if a small dressing is needed out of hours. Wound management policies and procedures are in place. Wound assessment, wound management and evaluation forms are in place for wounds. Wound monitoring occurred as planned. There were two residents with wounds. There were no pressure injuries. The facility has access to wound care specialist advice if required. Continence products are available. The residents' files include a urinary continence assessment, bowel management plan, and continence products used. Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, and food and fluid.
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	A diversional therapist (DT) is employed for 3.5 days per week and has been in the role since 2013. Caregivers and the owners assist with activities. The activities are provided from 10.30 am to 5.30 pm over six days a week. Group activities are provided in the large communal dining room, in seating areas and outdoors in the gardens when weather permits. Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance. Feedback from residents is through resident meetings and individual feedback. The DT was able to show where changes to the activity plan had been made because of resident feedback. On the days of the audit, residents were observed being actively involved in a variety of activities. The group activities programme is developed monthly, and a copy of the programme is available on noticeboards. The group programme includes residents being involved within the community with social clubs, churches and schools. The DT interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop a diversional therapy plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process. A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate, is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.
Standard 1.3.8: Evaluation Consumers' service delivery plans are	FA	All initial care plans reviewed were evaluated by the clinical manager or RN within three weeks of admission and a long-term care plan developed. Residents are reassessed using the interRAI process at least six-monthly. Long-term care plans are then evaluated and updated. There was documented evidence that care plan evaluations were current in resident files sampled. Care plan reviews are signed as completed by the

evaluated in a comprehensive and timely manner.		RN. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested, if issues arise or their health status changes. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required.
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 1 August 2019. The director/health and safety officer has responsibility for the maintenance and repairs of the facility. Maintenance requests are written into a log book and addressed daily. Essential contractors are available 24 hours. There is a planned maintenance schedule in place. Electrical testing is completed annually. Clinical equipment has been calibrated. There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to the well maintained, landscaped outdoor areas. Seating and shade is provided. The caregivers interviewed, stated they have sufficient equipment including mobility aids, wheelchairs, sensor mats and pressure injury resources (if required) to safely deliver the cares as outlined in the residents' care plans. Call bell audits documented that timely responses have been initiated. Sensor mats are linked into the call bell system as part of the service's falls prevention process.
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 collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data, including trends, analysis and audit outcomes are discussed at the quality meetings. The service completes monthly and annual comparisons of infection rates for types of infections. Trends are identified and analysed, and preventative measures put in place. The GPs monitor the use of antibiotics. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is	FA	There are policies around restraint minimisation. No residents were using restraints or enablers. The clinical manager is the designated restraint coordinator. Staff receive training on restraint minimisation. The caregivers interviewed were able to describe the difference between an enabler and a restraint and training has been provided.

actively minimised.		

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.

No data to display

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.