

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 BSI Group New Zealand Ltd, 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: 13 December 2021 End date: 14 December 2021

Proposed changes to current services (if any): One bedroom has been converted into a lounge and the owners requested the certified total bed numbers to decrease from 31 to 30.

Total beds occupied across all premises included in the audit on the first day of the audit: 27

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
Yellow	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
Red	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 is privately owned and operated. The rest home provides rest home level care for up to 30 residents. On the day of the audit there were 27 residents living at the facility.

This unannounced surveillance audit was conducted against the subset of health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, a family member, staff, management, and general practitioner.

One owner director is a registered nurse and is in the role of clinical nurse manager. The second owner/director (operations manager) has a business management background and is responsible for health and safety, finances, and maintenance. Residents and a family member interviewed were complimentary of the services they receive.

One shortfall identified at the previous audit around reassessment of pain remains.

There were no new shortfalls identified at this audit.

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.
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Discussions with a family member identified that they are informed of changes in their family member's health status. There are regular resident meetings where residents can provide feedback on all services. Complaint's policies and procedures meet requirements and residents, and families are aware of the complaints process. Complaints are managed appropriately and timely.

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.
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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, internal audits, meetings and health and safety processes. Adverse, unplanned, and untoward events are documented by staff.

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training are in place. There are adequate numbers of staff on duty to ensure residents are safe. There is a clinical nurse manager and part-time RN who provide registered nursing cover and available 24 hours on call when not on site. The residents' files are appropriate to the service type.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Registered nurses are responsible for all stages of service provision. Assessments, resident care plans, and evaluations were completed by the registered nurses within the required timeframes. Resident care plans are completed and included allied health professional involvement in resident care.

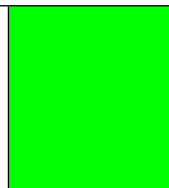
The diversional therapist implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Community links are maintained where possible within the Covid-19 risk management strategies. There are a variety of activities that are meaningful to the residents.

There are medicine management policies in place that meet legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. Electronic medication charts have photo identification and allergy status noted. Medication charts are reviewed three-monthly by the general practitioner.

All food and baking is prepared at the neighbouring facility. The menu has been reviewed by a dietitian. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

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 holds a current warrant of fitness and approved fire evacuation scheme. There is a reactive maintenance system and planned maintenance schedule in place. There has been upgrades made to the kitchen including new equipment.

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. During the audit there was one resident using an enabler and no restraints were 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. The registered nurse is the infection control coordinator. A suite of infection control policies and guidelines meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated. Covid -19 prevention strategies are implemented to manage risk.

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	15	0	0	1	0	0
Criteria	0	40	0	0	1	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and families during the resident's entry to the service. There is access to complaints forms and a suggestions box in a communal lounge.</p> <p>The clinical nurse manager is the privacy officer. There have been three internal complaints in 2020 since the last audit and three in 2021. One complaint lodge in December 2020 was investigated and resolved by the Health and Disability Commissioner (letter dated 20 October 2021). As a result of the investigation and recommendations documented, all staff completed another education session on the Code of Health and Disability Services Consumer Rights (the Code) delivered by the Nationwide Health and Disability Advocacy Service and the management of complaints. The clinical nurse manager completed training in management of complaints after adverse events and a critical thinking study day at the CDHB.</p> <p>A review of the complaint, investigation notes and letter to the complainant demonstrated compliance with HDC guidelines. A complaint register is maintained. Any concerns or complaints are discussed at staff meetings. Four residents interviewed stated the owners/directors are readily available to discuss any concerns they may have. Concerns are also addressed at the three-monthly resident's meeting.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The two owners (clinical manager and operational</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>manager) and four care staff (three caregivers and one diversional therapist) interviewed understood about open disclosure and providing appropriate information when required.</p> <p>There was documented evidence of family notification for changes to resident's health status. Eight accident/incident forms for the month of November identified that family members had been notified within a timely manner for incidents/accidents. One relative interviewed stated they receive email and phone call regular updates from the management team related to the implementation of Covid 19 prevention strategies including vaccination declarations and visiting hours.</p> <p>There are three monthly resident meetings chaired by the non-clinical owner/director. The meetings are open to families with good attendance and discussion on all aspects of the service. The service has Wi-Fi throughout the building including residents' rooms, improving communication for families with their loved ones.</p> <p>An interpreter service is available and accessible if required through the district health board. Families and staff are utilised in the first instance.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Fitzroy of Merivale is certified to provides care for up to 31 residents at rest home level of care. The owners have changed one bedroom into a lounge and requested the certified bed numbers be reduced to 30.</p> <p>At the time of the audit, there were 27 residents (including three privately paying non-assessed residents and one respite care resident).</p> <p>Fitzroy of Merivale has been privately owned for six years by two owner/directors (husband and wife team). One owner/director is the clinical nurse manager with a current practicing certificate, many years of clinical experience and oversees the clinical management. The other owner/director has a business management background and is responsible for non-clinical services(operations), finances and maintenance. They are supported by a part-time RN and long-serving staff.</p> <p>The 2021 to 2023 business plan has been reviewed regularly with ongoing goals. The business plan includes the service mission statement, philosophy, vision, and values.</p> <p>The clinical nurse manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility including attending DHB study days and infection control skills based DHB study day. The clinical nurse manager has also completed on-line management courses for business management, leadership, and quality management.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>A quality and risk management system is established. There is a quality and risk management plan in place for 2021. The service contract an aged care consultant to provide and review policies and procedures to align with</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>current accepted practice. New policies and updates to existing policies are discussed in staff meetings.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, meetings, health and safety, infection control and resident surveys. There are bi-monthly quality meetings open to all staff and care services/head of department meetings bi-monthly. Quality data, including accidents/incidents, infections and outcomes of internal audits is collated, analysed, and discussed at meetings as sighted in meeting minutes. Staff have access to meeting minutes in the staff room.</p> <p>An internal audit programme is being implemented. Internal audit results and corrective actions are discussed with staff in meeting minutes. Where improvements are identified, corrective actions are documented and signed off in a timely manner by the clinical nurse manager when actioned.</p> <p>Resident satisfaction surveys are completed annually each January with the last survey completed in 2020. The overall majority of responses indicated that residents were either satisfied or very satisfied with the service received. This was also confirmed during interviews with residents. Results were shared with residents, families, and staff. Corrective actions were implemented where areas of concern were identified. As a result of feedback a new van was purchased to improve the transport and outing experience for residents. The management team were in the process of collating responses from a recent 2021 satisfaction survey.</p> <p>The non-clinical owner/director is the health and safety officer with overall responsibility for health and safety. He has completed an on-line health and safety course, manual handlers course through a physiotherapist and is a qualified tester and tagger of electrical equipment. Staff receive health and safety training, which begins during their induction to the service and annually as part of the education plan. Health and safety are a regular topic covered in the quality and staff meetings. Actual and potential risks are documented on the hazard register (last reviewed August 2021), which identifies risk ratings and documents actions to eliminate or minimise the risk. Contractors' complete health and safety inductions. Staff complete safe manual handling competencies for the use of the Raizer (lifting device used in resident falls).</p> <p>Falls management strategies include sensor mats and reviewing residents at risk of falling at frequent intervals. A falls management plan is developed for each resident who is identified at a high risk of falling.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their</p>	<p>FA</p>	<p>The incident reporting policy includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action documented including any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme.</p> <p>Eight accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurologic observations are documented for any suspected head injury or unwitnessed fall. The clinical nurse manager or part-time RN signs off each event.</p> <p>The owners/directors are aware of their responsibility to notify relevant authorities in relation to essential</p>

family/whānau of choice in an open manner.		notifications. There have been no Section 31s reported or any outbreaks since the previous audit.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Five staff files reviewed (one RN, clinical nurse manager (RN), two caregivers, one diversional therapist) included evidence of the recruitment process, signed employment contracts, job descriptions, reference checking and completed job specific orientation programmes. Staff are required to be fully vaccinated against Covid19 to commence or continue employment.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. Competencies are completed specific to worker type including the use of PPE and hand hygiene. Staff interviewed stated that they believed new staff were adequately orientated to the service.</p> <p>A register of current practising certificates for the RNs and health professionals is maintained.</p> <p>The 2020 annual education schedule has been completed and the 2021 planner is being implemented and on track as per schedule. Staff meetings precede in-services with high numbers of staff attending. Staff who are unable to attend are provided with meeting minutes and education notes from the in-service. Staff attend mandatory training. Individual staff training records are maintained. Education is provided by the clinical nurse manager and external speakers such as the DHB dementia care facilitator, HDC advocate, food service provider and chemical safety provider. Continuous education around Covid19 management and prevention strategies have been delivered as part of the education schedule.</p> <p>The clinical nurse manager has completed interRAI training. An external Careerforce assessor is used. There is a total of 12 caregivers employed with four having level 4, three with level 3, one with level 2 qualifications and one currently enrolled. Staff who administer medications have completed annual medication competencies including insulin and second checker competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing policy aligns with contractual requirements. The clinical nurse manager and the part time RN (works 15 hours per week) share the RN cover Monday – Sunday morning duties on site and cover the on-call 24 hours.</p> <p>There are adequate numbers of caregivers available with one working the full morning shift (7am-3pm); and two on the short shifts from 7 am to 1 pm.</p> <p>On the afternoon shift there is one caregiver from 2.45pm-6.45pm; another from 6.45pm-11.45pm; and one caregiver from 5 pm to 8 pm.</p> <p>There is one caregiver on the night shift (11.30pm-7.30pm) with an RN on call. The clinical nurse manager and</p>

		<p>RN lives five minutes away from the facility.</p> <p>There is a diversional therapist (DT) on duty four days a week. Caregivers complete the laundry (only flannels and personal clothing) and there are separate cleaning staff. There is a morning and afternoon kitchenhand (meals are not cooked on site).</p> <p>Staffing is flexible to meet the acuity and needs of the residents. Interviews with residents and staff confirmed staffing levels were satisfactory.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All medicines are stored securely. Registered nurses and caregiver's complete annual medication competencies and medication education.</p> <p>Medication reconciliation occurs against the blister packs for regular and 'as required' medications. Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. There were no standing orders. The medication fridge temperature and medication room temperature are being monitored daily and both were within acceptable limits. All eyedrops were dated on opening.</p> <p>Ten medication charts on the electronic medication system were reviewed. One paper-based medication script was reviewed for the respite resident. All charts had photo identification and allergy status documented. The effectiveness of 'as required' medications were recorded in the electronic medication system. All long-term medications charts had been reviewed by the GP three monthly. There are no prn-controlled drug medication prescribed and one resident receive regular packed controlled drug medication for pain. This resident is stable and do not need or require regular RN assessments.</p> <p>There was one resident self-medicating with current self-medication competencies kept on file. The RN completes a weekly check of the medications to ensure stock is available and the resident has been taking the medication as prescribed. The medication was kept in a locked box in the cupboard (sighted).</p> <p>Nutritional supplements are prescribed and administered from the electronic medication chart.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of</p>	FA	<p>Meals and baking are provided by an off-site contracted service. A company dietitian approves the four-seasonal menu. Food control documentation was sighted. The food control plan was verified and expires 7 April 2022. The contractor receives resident dietary information including dislikes and food allergies. The clinical nurse manager/RN provides regular written updates on resident dietary needs. The clinical nurse manager states the kitchen manager of the contracted food service manages the needs of the residents well and there is regular communication between them. The main meal is served at lunch.</p> <p>Meals are transported to the facility kitchenette in a hot box and is served by the kitchen staff from a bain marie</p>

<p>service delivery.</p>		<p>to the residents through a hatch to the adjacent dining room. Any special dietary requirements are delivered in named containers. 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.</p> <p>All staff and kitchen hands involved in the preparation of breakfasts and serving of meals have attended food safety training. Residents interviewed were very complimentary about the meals and fruit platters provided. There is food, fruit platters, nutritional supplements, smoothies, and snacks and available in the facility kitchen should residents require this.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Care plans reviewed were goal orientated and met the resident needs. Residents interviewed stated their needs are being met. If a resident's condition changes the RN initiates a GP consultation and completes a short-term care plan. Not all pain assessments were completed where the pain site or pain intensity differed from the previous pain assessment. The shortfall identified at the previous audit around reassessment of pain) has not been addressed.</p> <p>There were five wounds (one chronic lower leg wound, one stage two pressure injury, one surgical wound, one skin tear, one infected toe) at the time of the audit. Wound assessments and plans had been completed for all wounds. Evaluations and change of dressings had occurred at the documented frequency. Chronic wounds had been linked to the long-term care plan. One resident with a chronic lower leg wound has been referred to a wound specialist and have input from the DHB plastic surgery outpatient department.</p> <p>There was an adequate supply of continence products available. A continence specialist is available to provide advice as required.</p> <p>Monitoring records sighted included weights, vital signs, neurological observations, bowel records, food and fluids, blood sugar levels, and pain. Resident weights were noted to be monitored monthly or more frequently if necessary.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the</p>	<p>FA</p>	<p>The diversional therapist (DT) is employed for 3.5 days per week and has been in the role since 2012. She has a current first aid certificate and attends on site in-services. The DT interviewed is knowledgeable about each resident's interest and participation. The DT confirm that the residents enjoy the new van that allows them to get out and about.</p> <p>The operations manager oversees the activities on a Friday and conducts the three-monthly resident meetings.</p> <p>The activities are provided from 10.30 am to 5.30 pm and involve a variety of recreational activities such as news reading, word games, crafts, quizzes, exercises, manicures, and garden walks. A current initiative is focused on developing life journals with residents, reflecting on their lives; the residents cut out pictures, and</p>

<p>setting of the service.</p>		<p>there is a story written about their memory of that activity.</p> <p>There are monthly church services, and weekly library services. Residents are encouraged to maintain links in the community including outings for lunch, cafés, shopping attending concerts and garden visits. There are twice weekly outings and/or mystery drives. Activities offered are meaningful and meet the residents' recreational preferences. Entertainment is organised over the weekend and the hairdresser attends weekly. The service utilises social media to keep relatives informed of outings and what the residents have been doing. Special events are celebrated, where residents dress up for the Melbourne Cup, cultural events, and Easter. There are family evenings organised where entertainment is provided. Resident's that do not want to attend group activities are included in one-on-one activities including hand massage and manicures.</p> <p>A resident profile is completed soon after admission. Each resident has an individual activity plan developed within three weeks, which is reviewed at least six-monthly. The service receives feedback on activities through one-on-one feedback, residents' meetings, and surveys. Residents interviewed were happy with the activities offered.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The initial care plan is evaluated in consultation with the resident/relative and long-term care plans developed. Long-term care plans reviewed had been evaluated six monthly or earlier for any changes to health. The resident/relative are invited to attend the multidisciplinary review (MDT) with the RN, caregiver, and DT. There is a written evaluation against the resident goals that identifies if the goals have been met or unmet. Long-term care plans are updated with any changes to meet the resident goals. Short-term care plans were evident for the care and treatment of short-term problems for residents, and these had been evaluated, closed, or transferred to the long-term care plan if the problem was ongoing.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The facility has a current building warrant of fitness that expires 1 August 2022. There is a maintenance person (owner/health and safety officer) available 40 hours a week and has overall responsibility for building compliance. The planned maintenance programme has been completed to date, including electrical testing, and tagging of electrical equipment, calibration and testing of clinical equipment, monthly call bell audits and monthly hot water temperatures. Hot water temperatures in resident areas are maintained below 45 degrees. Essential contractors are available 24-hours. There is a maintenance request book and staff interviewed confirm maintenance issues are dealt with in a timely manner.</p> <p>Room and ensuite refurbishments and upgrades continue as part of the maintenance plan. One room has been converted into a lounge and decrease the total number of beds from 31 to 30.</p> <p>The physical environment allows easy access/movement for the residents and promotes independence for residents with mobility aids. There is ramp access to different levels. Outdoor areas have landscaped gardens</p>

		<p>and well-maintained pathways There is outdoor seating and shade provided by the trees.</p> <p>The RNs and caregivers interviewed stated they have all the equipment required to deliver safe resident cares.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources, and education needs. Internal infection control audits on all areas of service assist the service in evaluating infection control needs. There is liaison with the GP and laboratory staff that advise and provide feedback/information to the service. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported at the monthly quality/staff meeting as sighted in meetings minutes. The surveillance of infection data assists in evaluating compliance with infection control practices. Infection rates are generally low.</p> <p>Covid 19 prevention strategies are included in the infection control and policies. The facility modified their approach under the Covid 19 traffic light system. Vaccination passports are required and scanned for all visitors. Residents were offered and received and consented to vaccinations. Covid tracing QR codes are displayed with notices at the front door. Visitors and staff are required to use masks.</p> <p>Visitors were observed using hand sanitizer. Staff were observed to practice good hand hygiene during the day and between residents.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraint minimisation. Fitzroy of Merivale is a restraint free facility. No residents were using restraints and one enabler was in use (creating a perimeter mattress with pillows). Consent, assessment, care plan and monitoring is completed as required for the enabler (at night when sleeping to promote safety). Risks and alternative measures were considered in the assessment and care plan. The clinical nurse manager is the designated restraint coordinator. Restraint education is completed at orientation and annually. Restraint minimisation and safe practice is discussed at staff meetings. Staff have received training managing challenging behaviours in 2021.</p>

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)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>There were short-term care plans in place for acute changes in health. Assessments were completed on a six-monthly basis but not always in response to new issues identified. The residents and staff stated the RN reviews care following an incident or acute change in health as sighted on incident reports and progress notes. Ongoing follow-up by the registered nurse was documented in each resident's progress notes.</p> <p>Pain management plans included the consideration of non-pharmaceutical interventions. The care plans were completed and noted change in health condition and pain site, however pain assessments were not always completed to reflect the change. Effectiveness of PRN pain medication had been documented in the progress notes. The shortfall identified at the previous audit around interventions has not been addressed. The risk rating has been raised in this audit to moderate and the length of time to address the issue shortened from 90 days at the last audit to 60 days.</p>	<p>There was no pain assessment completed for two residents a) one with a chronic lower leg wound who receives regular prn pain medication and b) one with a wrist fracture following a fall.</p>	<p>Ensure reassessments of pain are complete when a resident's condition changes.</p> <p>60 days</p>

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, there 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.