# Thorrington Village Limited - Thorrington Village

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Thorrington Village Limited

**Premises audited:** Thorrington Village

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

**Dates of audit:** Start date: 29 March 2016 End date: 30 March 2016

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 42

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Thorrington Village is owned by Archer Group. The service provides cares for up to 45 (30 rest home and 15 dementia) residents requiring rest home or dementia level care and up to a further 13 residents requiring rest home level care in studios. On the day of the audit there were 42 residents including those in the studios. The service is being overseen by a site manager who has experience in managing social services and is supported by a clinical manager, a general manager for the group and a quality assurance manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident’s and staff files, observations and interviews with residents, relatives, staff and management.

This audit has identified areas for improvement around notifying families of incidents, follow up of incidents, documentation of registered nurse input and care plan interventions.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Staff at Thorrington Village strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights. Cultural needs of residents are met. Policies are implemented to support residents’ rights and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Thorrington Village has a current strategic plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.

Aspects of quality information are reported to monthly quality meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at regular resident meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to quality meetings. Thorrington Village has job descriptions for all positions that include the role and responsibilities of the position. There is an annual in-service training programme and staff are supported to undertake external training. The service has a documented rationale for determining staffing. Healthcare assistants, residents and family members report staffing levels are sufficient to meet resident needs.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The care plans are resident and goal orientated. Input from the resident/family is evident in the service delivery. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three monthly general practitioner review. Residents and family interviewed confirmed that they were happy with the care provided and the communication.

Planned activities are appropriate to the resident’s assessed needs and abilities. Residents advised satisfaction with the activities programme.

There is a secure electronic medication system at the facility.

Residents' food preferences and dietary requirements are identified at admission and all meals cooked on-site. The kitchen is well equipped for the size of the service. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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. |

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. The memory support unit is secure and provides a safe homelike environment for residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate.

## Restraint minimisation and safe practice

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

There is a restraint policy that includes the provision of a non-restraint environment. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently no residents requiring restraints and no residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management.

## 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. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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 | 41 | 0 | 3 | 1 | 0 | 0 |
| **Criteria** | 0 | 89 | 0 | 3 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **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 Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (four caregivers - one from the rest home, one from the dementia unit and two who work across both, the clinical manager and the activities coordinator) confirmed their familiarity with the Code. Interviews with seven rest home level residents (including two who reside in studios) and two relatives (one from the dementia unit and one from the rest home) confirmed the services being provided are in line with the Code. The Code is discussed at resident and staff/quality meetings. |
| 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 | A detailed informed consent policy is implemented. Systems are in place to ensure residents and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.  Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.  A multipurpose informed consent form is utilised by the service provider and is retained in each individual resident’s record reviewed. Additional forms, for example, wound photographs, procedures and annual influenza vaccinations are in the records randomly selected and reviewed. Forms are signed and dated appropriately.  The admission agreements were signed and dated by the provider and the resident and/or representative. The clinical manager ensured these were all signed and filed in the residents individual records which are stored in a locked filing cabinet at reception.  The GP interviewed understood the obligations and legislative requirement to ensure competency of residents as required for advance directives and advance care planning. Resident reviews were undertaken six monthly. Reviews of the individual resident’s health status was documented and retained in each personal file reviewed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | There is a policy that describes access to advocacy services. Staff receives training on advocacy. Information about accessing advocacy services information is available in the entrance foyers. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested and the chaplain provides advocacy where appropriate. Interviews with staff, residents and relatives informed they are aware of advocacy and how to access an advocate. |
| 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 | Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents and relatives interviewed confirmed this and that visiting can occur at any time. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with residents and relatives demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  There is a complaints register. There have been seven complaints since the service was purchased nine months before the audit. All complaints since the previous audit were reviewed. Verbal and written complaints are documented. All complaints reviewed have noted investigation, timelines, corrective actions when required and resolutions. Results are fed back to complainants. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There are posters of the Code on display throughout the facility and leaflets are available in the foyers of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or EPOA to read with the resident and discuss. On entry to the service, the clinical manager discusses the information pack with the resident and their family/whānau. |
| 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 independence. | FA | The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident’s privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met.  There is a policy that describes spiritual care. Church services are conducted in the facility every week. All residents and relatives interviewed indicated that resident’s spiritual needs are being met when required. There is a chaplain employed 20 hours per week to ensure resident’s spiritual needs are met.  Staff interviewed were familiar with the policies and appropriate practices around the prevention and identification of abuse and neglect. |
| 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 | The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan.  Staff training includes cultural safety. The service is able to access Māori advisors as identified in the Māori health plan and policies. There were no residents identifying as Maori at the service.  Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. Discussions with staff confirm that they are aware of the need to respond to cultural differences. |
| 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 | The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that their cultural and individual values were being met.  Information gathered during assessment including residents cultural, beliefs and values is used to develop a care plan which the resident (if appropriate) and/or their family/whānau are asked to consult on. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility has a staff Code of Conduct which states there will be zero tolerance against any discrimination occurring. The clinical manager and site manager supervise staff to ensure professional practice is maintained in the service. The abuse and neglect process covers harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice that align with the Health and Disability services standards to meet the needs of residents requiring rest home and dementia level of care. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects satisfaction with the services that are provided. Residents and relatives interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and state that they feel supported by the management team. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident. This ensures full and frank open disclosure occurs. Ten incidents/accidents forms were viewed. The form includes a section to record family notification. Not all forms indicated family were informed or if family did not wish to be informed. Relatives interviewed reported they are notified of any changes in their family member’s health status. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Thorrington Village is owned by Archer Group who own one other care facility and another village. The service provides dementia and rest home level care for up to 45 residents and rest home level care for up to a further 13 residents in studios under license to occupy arrangements. On the day of the audit there were 42 residents including 11 residents in the dementia unit (named memory support unit) and 31 rest home residents (including five residing in studios and two on respite care, one on a long term chronic conditions contract and one on a young person with disabilities contract). Five of the rest home level residents reside in studio apartments in one wing of the facility.  The site manager has been at the service since it was purchased nine months before the audit and has business management and pastoral care experience. The clinical manager has been at the service for six weeks, having previously held leadership positions in a variety of nursing settings. Additionally the management includes a quality assurance manager and the Archer general manager. The Archer facilities are overseen by a board of directors and the organisation is a charitable trust. Archer has a strategic plan and Thorrington has a quality and risk management programme in place for the current year. The organisation has a philosophy of care which includes a mission statement. The site manager has completed in excess of eight hours of professional development since commencing employment. |
| 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 | In the absence of the site manager, the clinical manager is in charge with support from the Archer management team and care staff. |
| 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 | There is a quality plan that includes quality goals and risk management plans for Thorrington Village. There is evidence that the quality system is implemented at the service. Interviews with staff confirmed that quality data is discussed at monthly quality meetings for which all staff are provided with minutes and at the 9.15 am briefing five days each week. All quality data is comprehensively covered in the monthly quality meeting. The quality assurance manager supports the site manager in providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies have been reviewed regularly and updated to include interRAI requirements. .  Resident/relative meetings are held in both the rest home and the dementia unit.  Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. Incidents and infections are benchmarked against similar facilities and corrective action plans are developed when benchmarking results indicate a possibility for improvement. The service has a health and safety management system. There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies are implemented for individual residents and staff receives training to support falls prevention. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. Corrective action plans were developed for lower rating areas in the January 2016 surveys. |
| 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. | PA Low | There is an accidents and incidents reporting policy. Accidents and near misses are reported by caregivers, the clinical manager and residents, as investigated by the clinical manager. Short-term care plans support this. The follow up of incidents by the clinical manager is not well documented (link 1.3.3.4) and forms do not document causative factors and opportunities to minimise recurrence. Comprehensive analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly quality meetings including actions to address trends identified. Discussions with the site manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources management policies in place which include that the recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Eight staff files were reviewed (the clinical manager, an enrolled nurse the social events coordinator, the cook and four caregivers) and these evidenced that reference checks are completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2015 has been completed and the 2016 programme is being implemented. There are 18 caregivers who work routinely in the dementia unit and 10 have completed the dementia standards. The remaining eight are enrolled in the programme and have not been employed for one year. The clinical manager is able to attend external training including sessions provided by the local DHB. The clinical manager (recently employed) is enrolled to undertake interRAI training. Until this occurs, an interRAI trained registered nurse is contracted to undertake interRAI assessments. All employees have been employed by the service for less than one year (the new owners took over nine months ago) so annual performance appraisals were not yet due. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policies include staff rationale and skill mix. Sufficient staff is rostered on to manage the care requirements of the residents. The clinical manager works 40 hours per week, Monday to Friday and is on call at other times. The service is in the process of employing a second registered nurse to work 16 hours per week. Registered nursing support is provided for interRAI assessments by a contracted registered nurse and support can be provided by the other Archer Village service if required. An enrolled nurse is also employed full time. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away in the nurses’ station. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder. |
| 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 | The entry to the service policy includes requirements and procedures to be followed when a resident is admitted to the service. Admission agreements were signed in all resident’s sampled records. Admission agreements reflect all the contractual requirements. Residents and families reported that the admission agreements were discussed with them in detail by the clinical manager or general manager. All residents had the appropriate needs assessments prior to admission to the service. A pamphlet containing information about the service was sighted. The clinical manager ensures that residents are admitted to the service as per contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | A standard transfer notification form from the district health board is utilised when residents are required to be transferred to the public hospital or to another service. The yellow envelope is utilised with the transfer notification form. The clinical manager verbalised that telephone handovers are conducted for all transfers to other providers. The residents and their families were involved for all exit or discharges to and from the 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 | An electronic medicine management system is implemented to ensure that the residents receive medicines in a safe and timely manner. All prescribed medications were reviewed by the GP in a timely manner. Medicine reconciliation is conducted by the clinical manager when a resident is discharged back to the service.  Medication rounds observed in both areas identified that staff administering medications complied with the medication administration policies and procedures. Current medication competencies were evidenced in the staff files.  The system in place for the management of controlled drugs meets the required regulations and guidelines. The controlled drugs register was correct and a weekly stock-take is conducted by the clinical manager.  All medications were stored appropriately.  There were no residents who self-administered medications. The self-administration policies and procedures were in place. |
| 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 food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. All meals are prepared and cooked on-site by the catering manager and second cook. There was evidence of current food handling certificates.  Residents are provided with meals that meet their food, fluids and nutritional needs. The clinical manager completes the dietary requirement forms on admission and provides a copy to the kitchen. The kitchen board is updated regularly. Additional or modified foods are also provided by the service.  Fridge and food temperatures were monitored and recorded daily. Cooked meals are plated from the kitchen to the rest home and memory support unit. The meals were well-presented and residents confirmed that they are provided with alternative meals as per request. All residents are weighed regularly. Residents with weight loss problems are provided with food supplements. |
| 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 | There is a documented policy on decline of entry to the service. When a resident’s entry to the service is declined, the resident is referred back to the referrer to ensure that the resident is admitted to the appropriate level of care provider. The clinical manager reported that the district health board needs assessors and social workers contact the clinical manager to discuss the suitability of the resident prior to sending the resident’s family to view the facility. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The clinical manager (RN) utilises standardised risk assessment tools on admission and this assessment information is the basis in developing the resident’s initial and long-term care plans in resident files sampled. New residents are admitted using the interRAI assessment tool and the outcome scores were used as the focus of their long-term care plans in files sampled. There was evidence that new residents are assessed within the required timeframes. Two resident’s (dementia unit) re-assessments had been completed using the interRAI tool. Others in files sampled contained paper based risk assessment reviews as interRAI assessments were not contractually required. Cultural, sexuality and intimacy needs have been identified for the residents. There was an initial assessment completed for the resident on respite care to assess the risks and health needs. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans sampled were resident-focused and personalised. There was evidence that continuity of service delivery is promoted. Goals are specific and measurable. Long-term care plans sampled were reviewed and updated in a timely manner. Short-term care plans are developed and were evident in the sampled files. Interventions were sufficiently detailed to address the desired outcome/goal; the resident on respite care had no interventions recorded as part of the initial care plan process for the identified needs (link 1.3.6.1). Residents and families confirmed they are involved in the development of long-term care plans. Staff members reported they are informed about changes in the care plans. Integration of records and monitoring documents are well managed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Care plan documentation was comprehensive with the exception of one file. The interventions in managing acute health issues (including wounds) were documented in short-term care plans. Interventions are updated when the desired goals/outcomes are not met or when the resident’s response to the treatment is not satisfactory. Family members interviewed expressed satisfaction with the clinical care and that they are involved in the care planning of their family member. Healthcare assistants and the clinical manager interviewed state there is adequate equipment provided including continence and wound care supplies. There were three skin tears and one minor wound recorded in the wound register. Wound assessment forms and an ongoing assessment and treatment forms were not completed consistently for all wounds.  Monitoring occurs for weight, vital signs, blood glucose and challenging behaviour. |
| 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 | Activities provided are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. The social events coordinator has adequate training for the role and develops the annual activity plans with the residents when able.  The weekly activities are posted in the rest home and memory support lounges. The social events coordinator divides his time between the two units. Weekend activities are supported by caregivers. The activity plans sampled were well-documented and reflected the resident’s preferred activities and interests. The resident’s activities participation log was sighted. Interviewed residents and families verbalised the activities provided by the service are adequate and enjoyable. On the day of audit, residents were observed being actively involved in activities. A 24-hour activity plan is in place for all residents in the dementia unit and reflected de-escalating techniques when behaviour becomes challenging. Individual activity plans were reviewed six monthly in files sampled. The two younger residents’ activities plans were reflective of their needs and in maintaining community links. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Long-term care plans were reviewed and evaluated every six months or earlier as required in files sampled. The interventions in both long-term and short-term care plans were modified when the outcomes are different from expected. Recent reassessments have been completed using the interRAI tool. The interviewed residents and family members reported they were involved in all aspects of care and reviews/evaluations of the care plans. The family are notified of GP visits and three monthly reviews by phone call and if unable to attend, they are informed of all the changes. There is at least a three monthly medical review by the medical practitioner. |
| 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 | There are documented policies and procedures in relation to exit, transfer or transition of residents. There is evidence of referrals by the GP to other specialist services. The residents and the families are kept informed of the referrals made by the service. Internal referrals are facilitated by the clinical manager. One resident was assessed for a higher level of care and was awaiting transfer to an appropriate facility. |
| 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 | All chemicals were securely stored. Storage areas both inside and outside were locked. Chemicals were clearly labelled and safety material data sheets were available and accessible in all service areas. The hazard register is current. Staff interviewed confirmed they can access personal protective clothing and equipment at any time. As observed during the audit, staff were wearing gloves, aprons and hats when required.  Review of staff training records and interviews with healthcare assistants, laundry and cleaning staff confirmed that regular training and education on the safe and appropriate handling of chemical and waste and hazardous substances occurs. The chemical supply company visits each month to check that supplies are adequate and that staff are managing chemicals safely and efficiently. Audits are performed as part of the internal audit programme as evidenced on the audit schedule reviewed.  The maintenance staff member interviewed has a good knowledge of the responsibilities associated with this role in the organisation. Waste management systems meet legislative requirements. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. Handrails are installed in corridors, showers and toilets to promote safe mobilisation. The physical environment minimises the risk of falls and promotes safe mobility by ensuring the flooring is appropriate and secure, bathroom floors are non-slip and walking areas are not cluttered.  The room sizes are adequate and the lounge and dining area is small but functional and comfortable for the residents. An appropriate outside area is observed with an external pathway in and out of the unit.  Maintenance is undertaken by both internal maintenance and external contractors. Electrical safety test tag system shows this has occurred. Clinical equipment is tested and calibrated by an approved provider at least annually or when required. The facility is being maintained in good repair. All maintenance records were reviewed and are clearly documented. The current building warrant offFitness expires July 2016.  All external areas inspected were safe, secure and contain appropriate seating and shade.  Interviews with residents and family members confirmed the environment was suitable and safe to meet their needs. |
| 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 | There are sufficient numbers of toilets and bathrooms for the number of residents in the rest home and in the separate dementia unit. Privacy is maximised in both care settings. All bathrooms and toilets are maintained to a good standard, are disability accessible with easy to clean walls and floors. The hot water temperatures are monitored monthly. Review of the records reveals temperatures are all below 45 degrees Celsius and whenever it was out of range, corrective actions have been recorded. |
| 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 | There are adequate space in the bedrooms for the safe manoeuvring of mobility equipment. There is adequate space in both care settings. Residents can personalise their rooms. |
| 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 needs. | FA | The dementia unit (named memory support unit) has a lounge/dining area which is suitable for the residents and the care setting. There is adequate room for facilitating activities. Appropriate comfortable seating is provided and a quiet room is available for use. The rest home has one bigger lounge with adequate seating. The main lounge in the rest home is large and is used for functions, activities and opens to the outside garden area. Dining rooms and lounges are within easy walking distances to bedrooms. Residents interviewed confirmed they use their rooms or external areas if they want privacy or quiet time. All furniture is safe and suitable for the resident groups in each care setting. |
| 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 | A sufficient number of cleaning and laundry staff is allocated seven days a week to carry out these services. The service conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective. Where improvements can be made these are implemented. Current safety material data sheets about each product are located with the chemicals in each area of service. The chemicals are stored appropriately in locked cabinets at all times. The cleaner’s trolley is stored in a locked room when not in use. The chemical mixes are prepared from a wall mounted system which works effectively for both services. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The documented emergency management plan complies with all applicable statutory requirements. It continues to be reviewed and improved as necessary.  The service has an approved evacuation plan. The last fire evacuation drill was held March 2016. The trial evacuation report letter was sighted. Staff attendance is recorded in the training records. Civil defence equipment and resources are available and this was discussed with the maintenance person responsible. A gas barbecue is also available. The facility has back-up lighting, power and sufficient food, water and personal supplies to provide for its maximum number of residents in the event of a power outage.  The emergency plans and security systems meet regulation requirements. The staff are responsible for checking the facility for security purposes on the afternoon and night shifts. The dementia unit is key pad accessed by staff and family. The police would be summoned if and when required.  The nurse call system is appropriate for the size of the facility and call bells are accessible in the rooms, lounge and dining areas. |
| 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 | The rest home and dementia unit have adequate heating. The maintenance person interviewed ensures the heating systems are running smoothly and that appropriate checks are performed.  There are sufficient doors and external opening windows for ventilation .All bedrooms have good sized external opening windows which are designed and installed to promote ventilation and to be secured as needed. In the rest home the main lounge doors open out to a garden area.  The residents and family interviewed confirmed the internal temperatures and ventilation are comfortable during the summer and winter months. |
| 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 | Thorrington Village 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 into the quality management system. The clinical manager is the designated infection control coordinator with support from all staff and the quality management team as the infection control team. Quality meeting minutes are available for staff. Infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has not yet been reviewed annually as the service has not yet been operating the facility for one year. |
| 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 clinical manager at Thorrington Village is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team has good external support from the local Laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is 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 | The service has an overarching infection control programme policy that links to Bug Control infection prevention and control policies, which are available at the service. These infection control policies and procedures are appropriate for the size and complexity of the service. The Bug Control infection control manual outlines a comprehensive range of 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 | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred, provided by an external infection control specialist. The infection control coordinator has completed online infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| 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 infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection and is benchmarked with similar facilities. Short-term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and compared month by month. Outcomes and actions are discussed at quality meetings and daily staff briefings and results posted for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the site manager. There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimized and provides a restraint-free environment. There were no residents with restraint and no residents with an enabler. Enabler use is voluntary. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP) and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | The service has procedures where all incidents are reviewed by the clinical manager and either the staff reporting the incident or the clinical manager are delegated the responsibility to inform the family. Families interviewed believed they are well informed. Two of the ten incident forms sampled documented that family were informed, either on the form or in the progress notes. | There was no documented evidence of family having been informed for eight of ten incident forms sampled. | Ensure family are informed of all incidents and that this is documented.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | All incidents are reported by the staff member who identifies the incident on an incident form. Incident forms are provided for the clinical manager to review. All incident forms sighted had been signed by the clinical manager but documented evidence of follow up of incidents is lacking. Interviews and short-term care plans indicate that follow up occurs and this is a documentation issue (link 1.3.3.4). Incident trends are discussed at quality meetings and opportunities to remedy unwanted trends are discussed. However not all incident forms documented analysis of cause or identified opportunities to minimise recurrence. | Nine of ten incident forms sampled did not document the causative factor or identify opportunities to prevent recurrence. | Ensure all incidents identify the causative factor and opportunities to prevent recurrence and that this is documented,.  90 days |
| Criterion 1.3.3.4  The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | Verbal handover between shifts is comprehensive. Healthcare assistants interviewed stated they are well informed of any changes in a resident’s health care status. In addition to handovers, when each shift starts there is a briefing meeting with the site manager and clinical manager at 9.15 each weekday morning. The clinical manager is on call for clinical issues that needs attention after-hours and on weekends. Progress notes are recorded daily by healthcare assistants and are comprehensive; however the registered nurse does not enter consistently in the progress notes. There is also a lack of registered nurse/clinical follow up evident in the progress notes following adverse events, for example, after a fall and introducing a wound treatment regime. Interviews and supporting documentation (for example care plan updates and short-term care plans) provide evidence that this is a documentation issue, not a practice issue. | i) Four (two rest home residents and two residents in the dementia unit) of the seven files show the registered nurses do not enter consistently in the progress notes; and ii) the registered nurses do not consistently follow up after adverse events in eight of ten incident forms sampled, for example, skin tears and falls. | i) Ensure the registered nurse documents clinical input and follow up in the progress notes.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Five of the six files care plan documentation was comprehensively documented. The respite care resident (rest home) has admission documentation and an initial assessment; however, the initial care plan documentation had no recorded interventions to manage the needs of the resident. Four wounds were recorded in the wound register. Two of the current wounds management documentation includes a wound assessment, wound management plan, evaluation and short-term care plan linked to the wound management plan. Both of these two wounds evidenced wound management was completed within the stated frequency. The other two current wounds managed had only a short-term care plan but no wound assessment documentation, dressing frequency etc. | i)There were insufficient interventions recorded to manage the needs of the resident on respite care and ;ii) Two of the four current wounds have no wound assessment , plan or review documentation completed. | i)Ensure the care plan interventions reflect the support needed to manage the health needs of all residents including those on respite care ;and ii) Ensure that a wound assessment, plan and reviews are completed for all wounds.  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.

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End of the report.